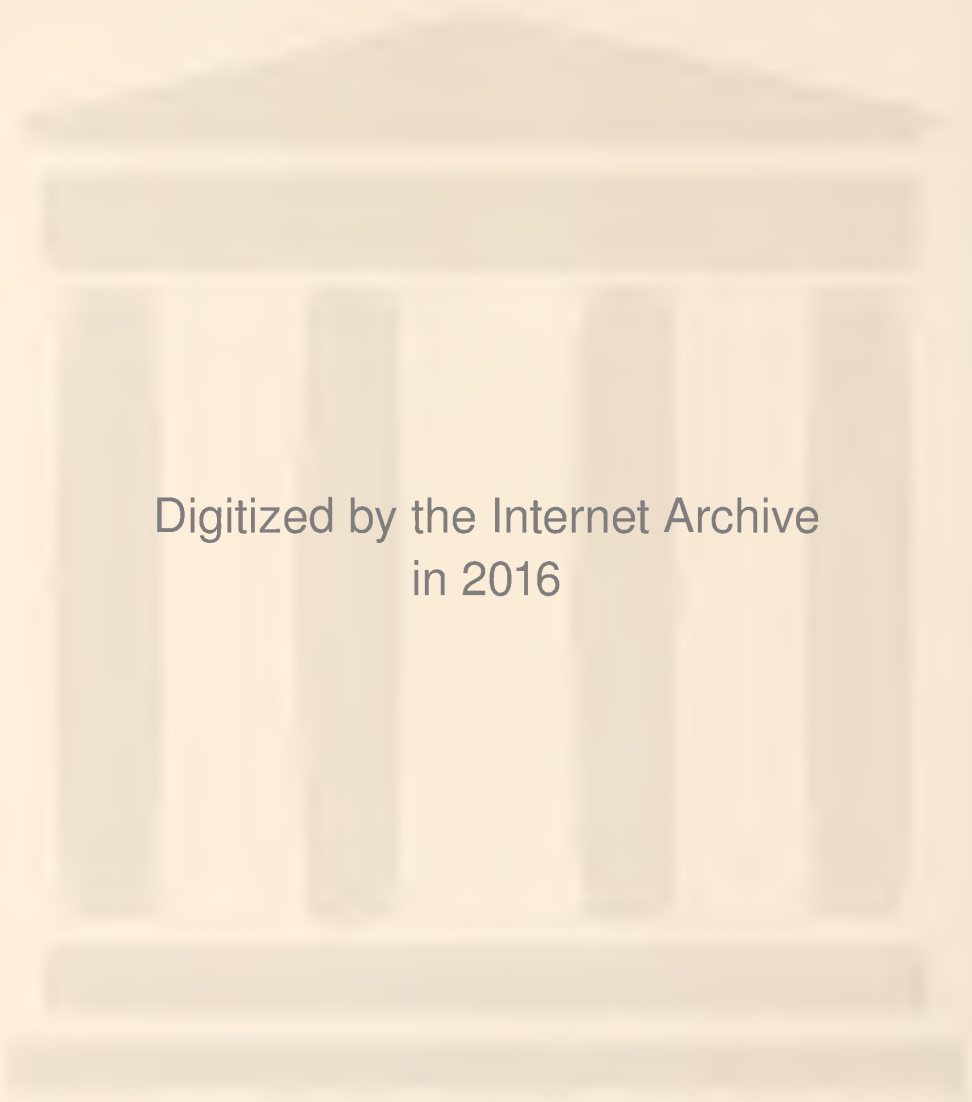
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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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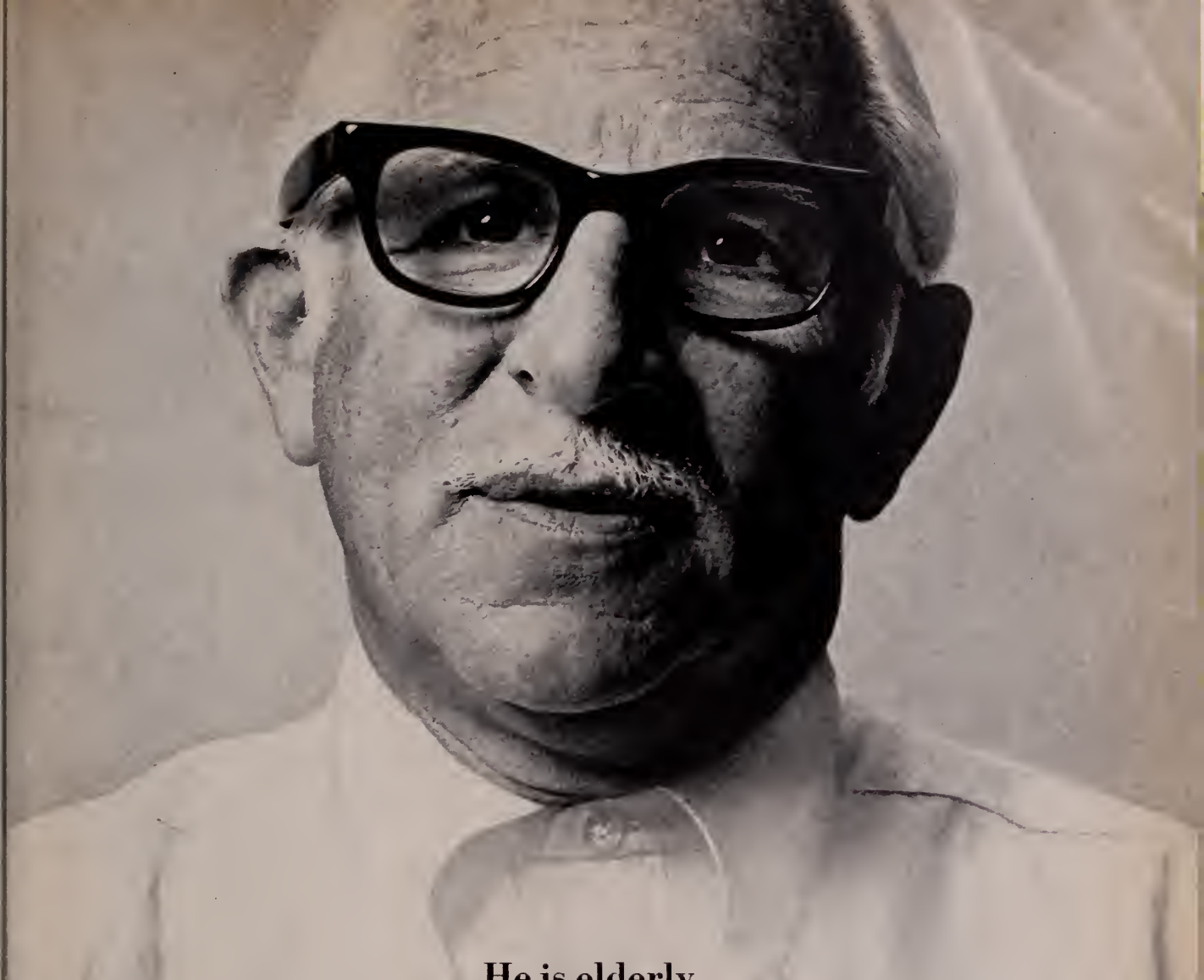
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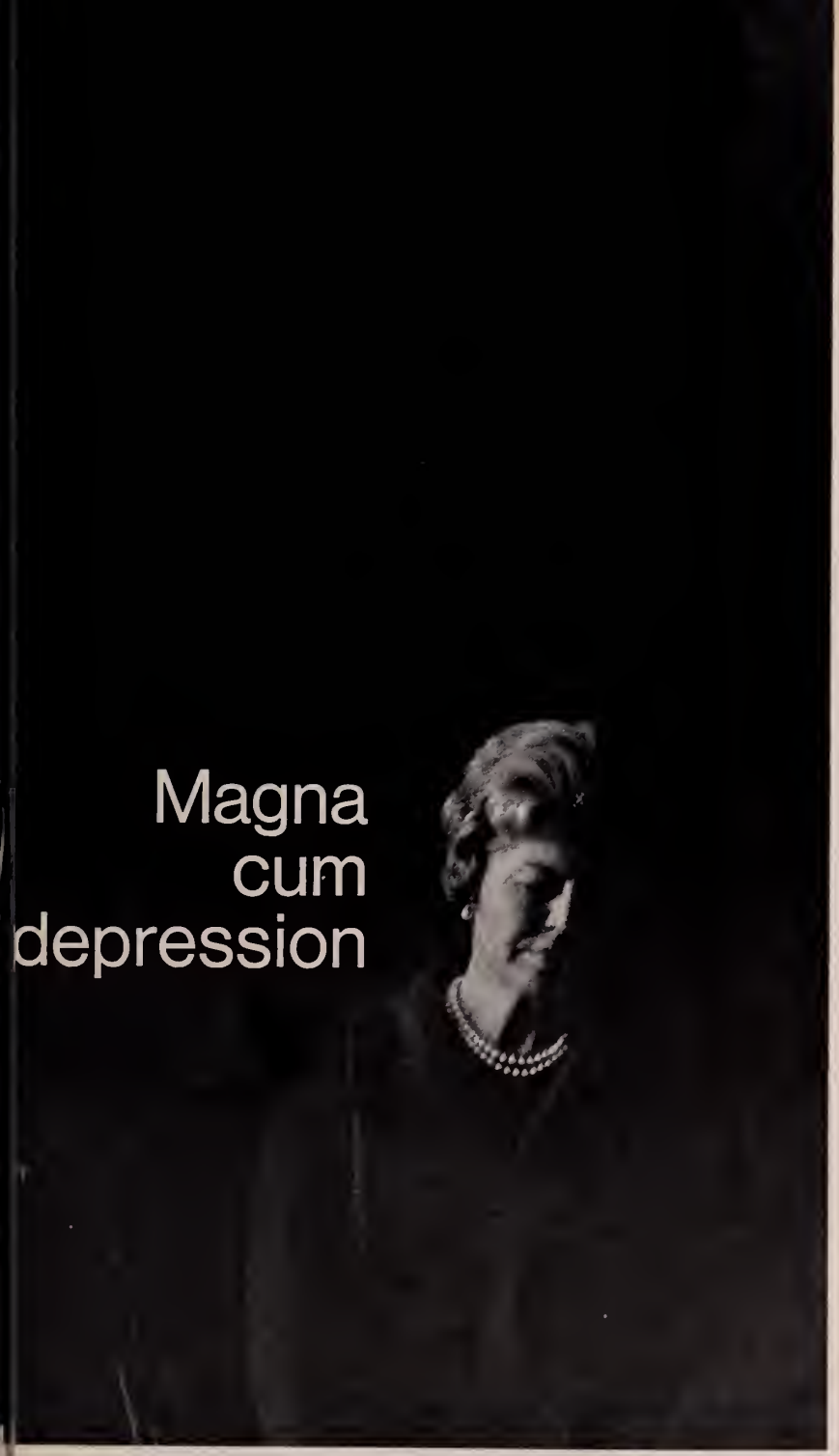
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An Open Letter

To The Members Of The Medical Society of New Jersey

Since assuming the responsibilities of President of Medical-Surgical Plan of New Jersey a few weeks ago, I have been frequently asked how I felt about this change, after 32 years in the private practice of medicine.

Well, it's interesting. There's no doubt about that. And challenging. There is much to be done in these times of dynamic change in the health care field.

But in some respects it's like being able to devote full time to a hobby. Blue Shield, and all that it stands for, has been an avocation of mine since the Plan was founded 26 years ago, and has occupied a good deal of my attention as a Plan trustee for the last 15 years.

We all know that Blue Shield owes its existence to its Participating Physicians. In my opinion, the contribution of these physicians is greater today than ever before. As a practicing physician, I have known some of the personal sacrifice entailed in implementing the Blue Shield concept — quality medical care, through free choice of physician, for persons of modest means at a cost they can afford, and for fees that the Plan can afford.

But times have changed since Blue Shield started. The economy — including the medical economy — has moved upward. Blue Shield must move with it. Our Prevailing Fee program is the first big step in the right direction, and promises to become the biggest thing of the future. Every doctor should sign up to participate in Prevailing Fee; if you haven't, I urge that you do.

Meanwhile, we must take other steps to update income limits for today's workers, and pay fees that are realistic in relation to higher incomes. These things are well on their way on the drawing boards, right now.

I very much enjoyed the opportunity, at the Society's recent convention, to talk informally with doctors from all over the State, as well as the opportunities for dialogue at Reference Committees, the House of Delegates, and the Open Discussion on Medical-Surgical Plan. We need open lines of communication, both formal and informal, between the profession and the Plan, and I intend to do all I can to see that we have them.

The Plan is fortunate in the choice of the new Trustees recently elected to the Board. Dr. Donald T. Akey and Dr. Henry J. Mineur are well-established — relatively young — and well-respected physicians in the fields of surgery and cardiology. Mr. James T. Crowley, an executive of Moore-McCormack Lines, brings a background in both labor and management to the Board; perhaps more importantly, as the father of four children he learned early in life the importance of budgeting health care for a growing family by means of voluntary insurance.

I appreciate this opportunity of sharing some of my thoughts with you, and look forward, with your cooperation and support, to an even brighter future for Medical-Surgical Plan.

Cordially,

Joseph P. Donnelly M.D.

Joseph P. Donnelly, M.D.
President

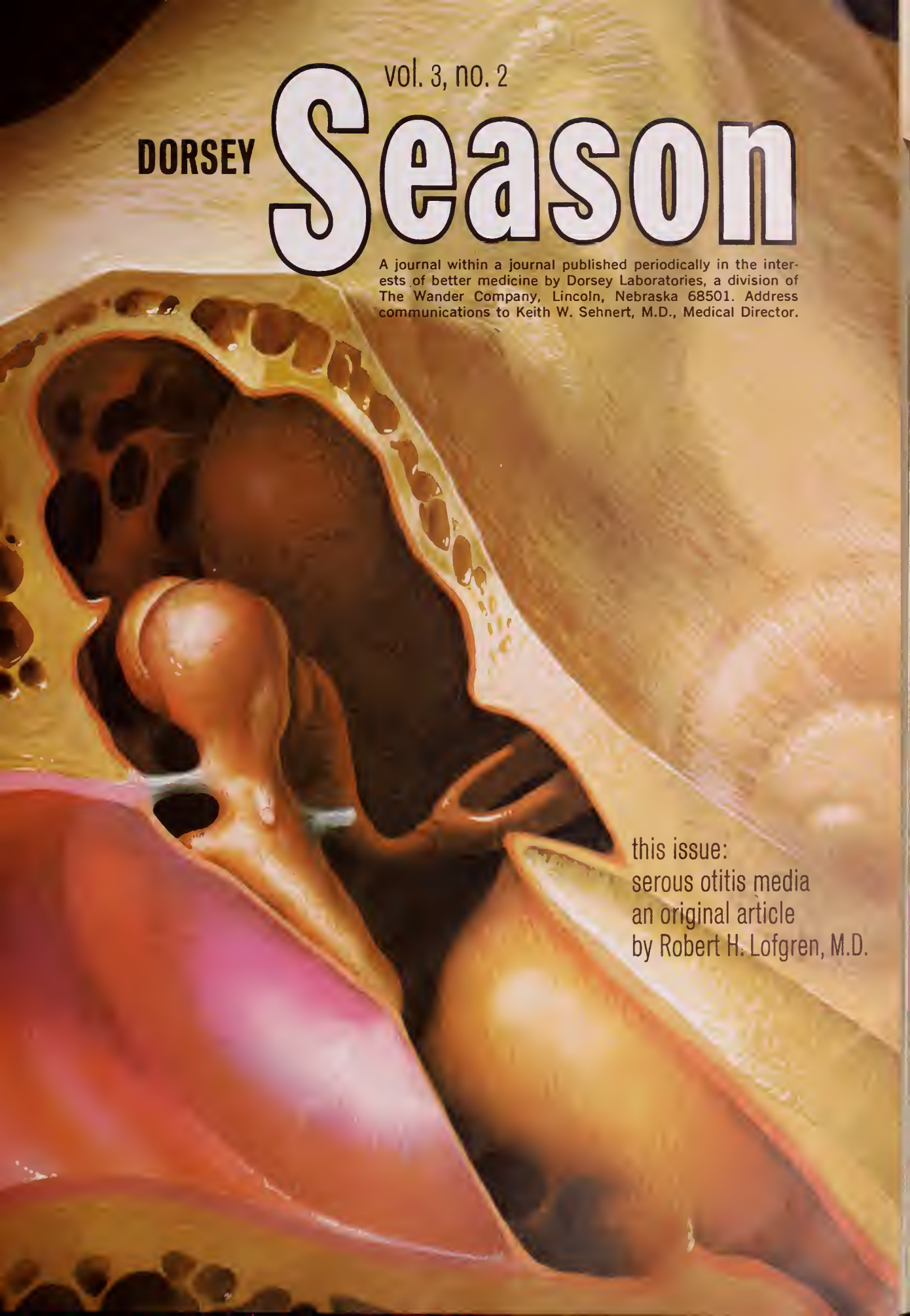
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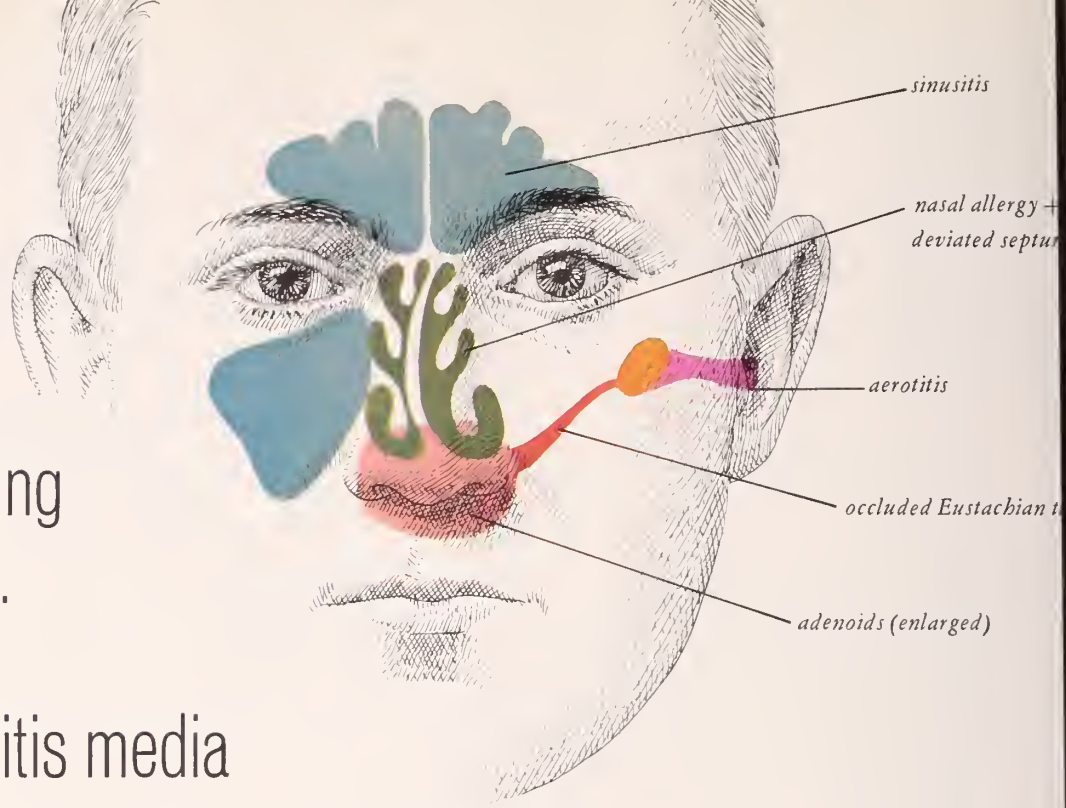
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

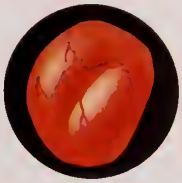
Otoscopic Views



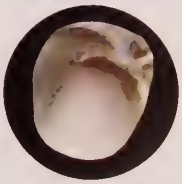
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

References 1. Senturia, B. H. et al.; Middle Ear Effusions: Pathologic Changes of the Mucoperiosteum in the Experimental Animal, Ann. Otol. 71:632-648, 1962. 2. Grahne, B.; Serous Otitis Media, Acta Oto-Laryng. 58:1-8, 1964. 3. Sade, J.; Pathology and Pathogenesis of Serous Otitis Media, Arch. Otolaryng, 84:297-305, 1966. 4. Buckingham, R. A. and Ferrer, J. L.; Reversibility of Chronic Adhesive Otitis Media with Polyethylene Tubes, Laryngoscope 76:993-1014, 1966. 5. Chalat, N. I. and Lounsbury, E.; A Hearing Phenomenon and Serous Otitis, Laryngoscope 76:983-992, 1966. 6. Shucknecht, H. F.; Chronic Otitis Media in Children: A New Treatment, Clin. Pediat. 3:718-727, 1964. 7. Feuerstein, S. S.; Surgery in Serous Otitis Media, Laryngoscope 76:686-708, 1966. 8. Kapur, Y. P.; Serous Otitis Media in Children, Arch. Otolaryng. 79:38-48, 1964. 9. Silverstein, H., Miller, G. F., Jr. and Lindemman, R. C.; Eustachian Tube Dysfunction as a Cause for Chronic Secretory Otitis in Children, Laryngoscope 76:259-273, 1966.



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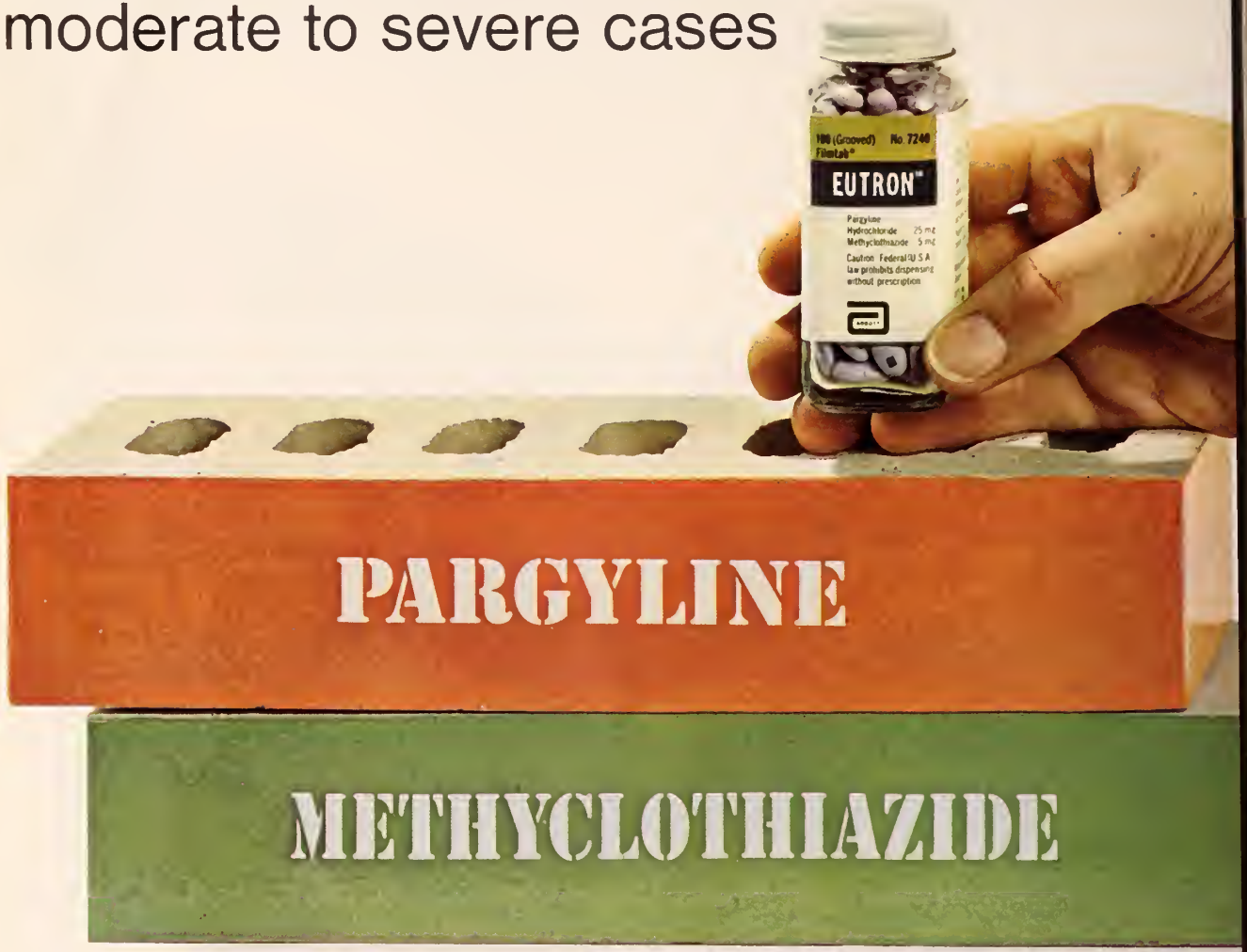
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801094

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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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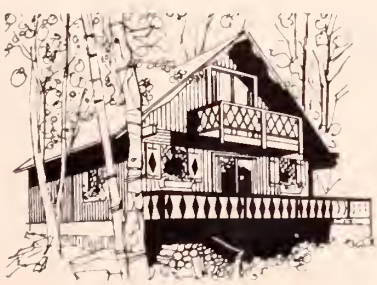
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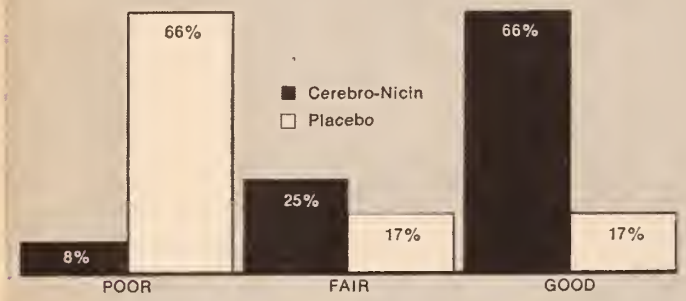
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Thiamine HCL	10 mg.

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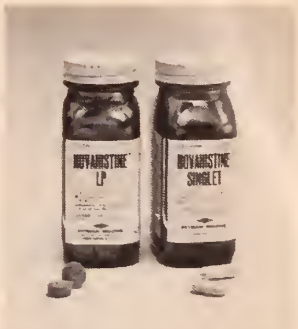
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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. DOSE. One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRA INDICATIONS See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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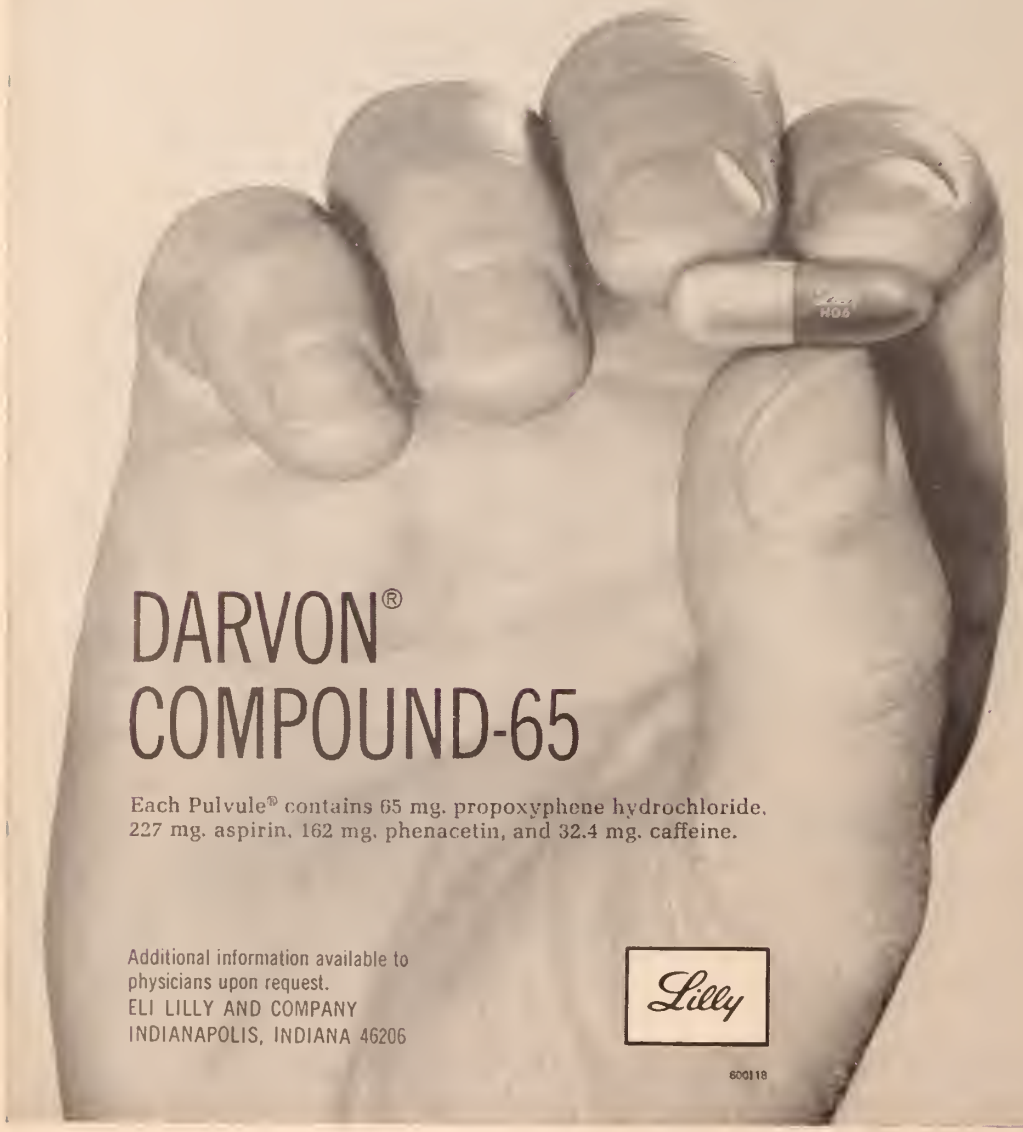
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EDITORIALS

The Medical Imposter In The Hospital

Hospitals are having a hard time getting physicians to serve them on salary in certain staff positions and in the emergency room. In view of this need — sometimes desperate — it is understandable that a hospital may appoint an unlicensed physician if he is, indeed, licensed in another jurisdiction or even in another country. The next step is to accept the *bona fide* medical school graduate who is not licensed anywhere. And then someday, a very pleasant fellow, with a fluent tongue, an easy manner, and a high degree of self-confidence will come along and he may be appointed because the hospital simply has not double-checked the credentials. He may, for instance, give as a reference a friend whose credentials are questionable, but who is not checked by the hospital. And finally, the out and out imposter may work his way in. Dr. Crosby, the executive director of the American Hospital Association, has reminded us that hospitals have the "responsibility to assure the public that members of their medical staff who claim to be physicians are in fact physicians. Several recent disclosures of unlicensed or uncertified physicians working in hospitals have received widespread publicity. One medical impostor on a hospital or clinic staff is a source of embarrassment to the institution as well as the medical profession."

The simplest and swiftest method is to check the detailed files of physicians in the AMA office in Chicago. They have the backgrounds of, believe it not, more than 300,000 physicians in their files — AMA members, nonmembers, American trained and foreign trained, but working in the USA. Your hospital can get the data at a cost of six cents (postage to Chicago) by writing to the Circulation and Records Department at 535 North Dearborn Street. And your county medical society might also make use of this service. It's a bit of trouble to write and wait a week for the answer. But that's nothing compared to the trouble your hospital or association might get into by not checking.

The honest M.D. will welcome this simple check-out. Only the imposter has anything to fear. *Verbum sat sapienti!* and in this case, "sap" means wisdom.

The Research Dollar

Gone are the days of the lone researcher, pouring over retorts in the barn or the attic. Modern research is a matter of team work, in stream-lined laboratories with chrome-plated gadgets. A single piece of modern research equipment may cost as much as a busy practitioner's annual gross income. Perhaps some new Curie, Pasteur, or Koch may flash across the scientific firmament in the future, a lone worker with shabby equipment. But the odds are against it. The single, dedicated worker in his basement laboratory has probably gone the way of the one horse shay, the little black bag, and the elegant four-ingredient prescription.

But the new research brings new problems. Finances did not seem so important when the major components of a research project were a high I.Q., a lot of sweat, an indefatigable body and spirit, and ten dollars' worth of wires, glassware and needles. It now takes a king's ransom just to investigate a proposal deep enough to find out if it is worth investigating further. And from what king will this ransom come? Government is wary of spending the tax-payer's dollar on a proposition that, 99 out of 100 times, will just lay an egg. And science is chary of accepting Government's dollar unless it can be made unequivocally clear that he who pays the piper will *not* call the tune. The pharmaceutical houses, God bless them, do pour millions and millions of dollars into research projects in the hope that one in twenty will pay off. Sometimes the fruit of the research hurts the company that puts up the money. And it is

not fair to place companies in *that* spot very often. Medical schools are good places for research, but medical schools have to pass the hat every once in a while just to make up their operating deficits. The big money for research probably has to come from the place where the big money is: which these days means the Foundations. And this is poetically just. Most of the Foundations draw their funds from business enterprises. It seems only proper that the money which came from consumers should now be used for their benefit. Of course there are some who just don't like the Foundations. None of these critics, however, have suggested any better source for the research dollar.

"For This Relief"

"He treats the symptoms only" is intended as a term of contempt. A doctor finds himself apologetic if he wants to relieve the symptom before he has worked out the basic pathology. Indeed, a certain amount of snobbery has developed around this. There are medical scientists who feel that anything short of definitive cure is unworthy of their efforts. Such selfless scientists view with ill-concealed disdain the "practitioner" (sometimes the "mere practitioner!") who seeks to relieve his patient's symptoms. Medical education is falling more into the hands of scientists and less into the hands of practitioners. So it seems likely that younger doctors will increasingly concentrate on removing the disease process rather than relieving the symptom.

And in a way this is too bad. Few diseases can be "removed," but most complaints can be assuaged. The doctor who withholds this balm is not giving his patient all that medicine can offer. True, there *are* certain dangers in treating symptoms. For instance, it is argued that if the patient's symptom is relieved, he won't follow through on definitive treatment. But it seems to us that the reverse is equally true. If the doctor does not speedily relieve the complaint, the patient will lose interest in the doctor. It is true that some medications have side-effects, but the danger of abuse is never a sound argument for withholding a benefit.

Anxiety and distress definitely aggravate disease—not only psychically but somatically, not only emotionally but physiologically. To relieve a symptom is to reply to a distress signal. To ignore the symptom is to hurt the doctor-patient relationship. With so extensive an inventory* of drugs, there are few symptoms which cannot now be relieved. And to give solace is surely one of the physician's prime duties.

Opiferque

On the seal of The Medical Society of New Jersey appear four Latin words, *Opiferque per orbem dicor.* A century ago, physicians were well enough educated to be able to read this motto at sight. Not only that, but they knew it was a quotation from Ovid and that it meant: "Throughout the world, I am called the Help Bringer:" *Op*—good things, such as wealth (as in opulent); *fer*—to carry or bring (as in ferry); *que*—and. It was Apollo's description of himself — Apollo, the pre-Aesculapian god of medicine: *inventum medicinae meum est, opiferque per orbem dicor; et herbarum subjecta potentia nobis.* To most of us today that's as much Greek as Latin, but to our spiritual ancestors it was simple: "The art of medicine is my discovery, and I am called Help-bringer throughout the world; and the power of all herbs is known to me."

So . . . just in case you are asked, "What is the motto of The Medical Society of New Jersey?" — or if some inquiring teen-ager wonders what those Latin words mean and turns to you, presumably the beneficiary of a classical education, you can tell him: "Throughout the world, I am known as the bringer of help."

* Not, you will notice, "an armamentarium." That phrase, like "broad spectrum," has finally been retired from the medical editor's lexicon, as having become worn out from overuse. Farewell to therapeutic armamentarium, RIP.

202nd ANNUAL MEETING
MAY 18-22, 1968

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 202nd Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in bold-face small type.

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ANNUAL REPORTS

President

Louis K. Collins, M.D., Glassboro
(Reference Committee "A")



This year for me has been exciting, interesting, and busy. The following trite statistics are self-explanatory. As this report is being written, the first ten months of my "tour of duty" have passed. I have travelled far and wide via air, train, and my faithful Buick – 21,230 miles to be exact. There were 98 meetings, 43 of which took place in Trenton. I journeyed to 30 cities in 11 states, visited 15 New Jersey counties, and spent 110 days – or major parts thereof – absent my office.

Especially informative were the conventions of the New York, Pennsylvania, Connecticut, and Delaware State Societies. There similar problems, their varied approaches toward solutions, their convention formats, all convince me that we have one of the best meetings right here. We are not perfect, but we do a pretty good job for less "dues" than most others. I must mention the cordial hospitality afforded my wife and me at these affairs. I also got the feeling that New Jersey is pretty well thought of in these states, as well as in the AMA.

One of the "fringe benefit" highlights was an inspection tour of the United States Air Defenses in Oklahoma, Texas, New Mexico, and NORAD in Colorado Springs, courtesy of the New Jersey National Guard. This visit was fully described in the January *Journal* of The Medical Society of New Jersey.

Perhaps the most memorable meeting was while sitting on the dais at the State Chamber of Commerce dinner in Newark, having the guest on my right hand, General James Cantwell, New Jersey National Guard, whisper in my ear that there was going to be a Summit meeting at Hollybush, Glassboro, the next day.

My one-year tenure on the Boards of Trustees of Blue Cross and Blue Shield really opened my eyes. Both groups are trying strenuously equitably to meet the many demands for changes of all sorts from hospitals, doctors, industry, and the public. Both are working on plans for Medicaid –Title 19, if either should be designated as fiscal intermediary. We were all saddened by the death of Dr. Nicholas Alfano, President of the Medical-Surgical Plan. He will be hard to replace.

Visits to county societies were always a pleasure and the treatment was royal. From questions asked by the members, I still feel that our communications with the "grass roots" could be improved. My wife and I were also guests at many other allied and friendly group dinners: the New Jersey Bar Association, the New Jersey Pharmaceutical Association, the New Jersey Dental Society, the New Jersey Academy of General Practice, and the New Jersey Association of Osteopathic Physicians and Surgeons, to name a few. We were greatly honored to dine with the AMA officers and trustees and their wives at Smithville Inn before the June Annual Meeting in Atlantic City. At the fall Clinical Meeting of the AMA in Houston, I had the privilege

of speaking successfully in behalf of Atlantic City as the site for the 1971 Annual Meeting. (A resolution had been introduced to "dump" Atlantic City.) In Houston, also, I had the extreme pleasure at the House of Delegates of accepting two plaques from the AMA-ERF for Mrs. Marion Plonske and Miss Marion Plonske of Short Hills, New Jersey. These two fine ladies presented a large bequest from the late Dr. Plonske's estate to AMA-ERF. In February, I presented the plaques in person to Mrs. Plonske and Miss Plonske at their Short Hills residence. The AMA and I agreed that such generosity should not go unrecognized.

As a member of the Advisory Group to the Regional Medical Programs of both New Jersey and the Greater Delaware Valley, I am more firmly convinced than ever that a spirit of full cooperation must exist between the two "heart, stroke, and cancer" organizations in order to really accomplish something constructive for us physicians, our ancillary personnel, and our patients themselves.

Last May I mentioned some legislative goals. The only one to become law so far has been "The Medical Examiner System." However, many other bills that we support and have introduced are in the "hopper," and we hope will be enacted during this session. Our continuing interest in Medicaid — Title 19 — will be discussed in other reports.

No report from any President of this Medical Society would be complete without praising the untiring efforts of our most efficient staff at 315 West State Street. From the scrubwoman to the Major Domo (Sir Richard), my heartfelt thanks for their support and never-ending labors for me and you. No task was too much; no request for assistance was ever denied.

I am sorry to mention that two of our "good and faithful servants" are resigning shortly, our fine legal counsel, Mr. Robert Backes, and our exceutive assistant, Miss Theresa Goeke. We will all miss them!

Again my thanks to all who helped make this a memorable year for me. I trust that my service as your 175th President was honorable and just. At any rate, it was wholehearted.

Approved (page 394)

1967 TRANSACTIONS

At its first session on Saturday, May 18, 1968, the House of Delegates approved, as corrected, the Transactions of the 1967 House of Delegates as published in the July 1967 issue of THE JOURNAL and distributed to the membership.

The correction—the result of a printer's error—is as follows:

Exhibit #5, page 336 . . . The action of the House should read "not adopted" instead of "no action."

Secretary

Marcus H. Greifinger, M.D., Newark
(Reference Committee "A")



The office of the Secretary has continued its usual routines, primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in Atlantic City and the Clinical Meeting in Houston, Texas — serving in a dual role as MSNJ Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership

(As of December 31, 1967)

Active: Paid	6,508	
Exempt	436	6,944*
Associate: Paid	376	
Exempt	58	434*
State Emeritus		189
State Honorary		9
New and Reinstated Members:		
Active	224	
Associate	242	466
Transfers within the state		26
Transfers out-of-state and resignations		75
Members deceased		102
Members dropped:		
Active (non-payment of dues)	31	
Associate (non-payment of dues	14	45

AMA Membership

A total of 6,112 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates — one for each thousand members, or fraction thereof.

Membership Directory

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1968. At this time it is expected that distribution will be made to the entire membership.

The new *Directory* will embody the same features as that of the 1966-67 edition. These include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) designates "Armed Forces," a single dagger (†) designates associate, and a double dagger (††) designates emeritus membership; (3) the hospital section of the *Directory* will include again the staff listing of proprietary hospitals; (4) the special membership supplement section — which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Legal Hazards of Medical Practice in New Jersey, a list of Poison Control Centers in New Jersey, and the Basic Concepts Underlying Provision of Professional Medical Care — will also include pertinent amendments to the New Jersey Radiation Protection Code, and information on the New Jersey Unincorporated Business Tax and the New Jersey Personal Business Property Tax.

One innovation is the planned inclusion of the zip code as the last item in each individual listing.

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* Adjusted for transfers out-of-state, resignations, and deaths.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1968-69 edition, as did the information data sheets which were supplied to publish the 1966-67 *Directory*. With the cooperation of the membership, it is the hope of your committee to make this forthcoming *Directory* the most complete and accurate edition yet published.

Approved (page 394)

Treasurer

Samuel J. Lloyd, M.D., Trenton
(Reference Committee "B")



This 1968 interim report of your Treasurer has been prepared from the books and records of The Medical Society by the Society's outside auditors.

The Balance Sheet is presented as of April 30, 1968 without audit or verification, for the reason that the current fiscal year of the Society does not end until May 31, 1968. Audited figures and a complete report of audit will be prepared and submitted for the fiscal year ended May 31, 1968.

The Statements of Cash Receipts and Disbursements have been prepared, without audit, on a cash basis and do not purport to show the results of operations for the period indicated.

The Statements of Receipts and Disbursements cover the cash transactions in the office of the Treasurer for the twelve months from May 1, 1967 to April 30, 1968. This period comprises one month of the 1966-67 fiscal year and eleven months of the current fiscal year and is so presented in conformity with the suggested form of prior years.

Cash receipts were checked, by the auditor, in full for the period and disbursements checked to supporting vouchers. The cash balances at April 30, 1968 were reconciled with the bank statements but were not confirmed direct with the depositories. Receipts from Counties for dues' assessments were checked in detail to reports on file, but were not confirmed with the County Treasurers at this time.

Your Treasurer has investigated the feasibility and wisdom of obtaining greater return on investments as recommended by the 1967 House of Delegates.

An outline containing several proposed alternatives to increase our investment income was prepared by the First Trenton National Bank. After considerable study by your Treasurer and members of the Finance and Budget Committee, the Trust Division of the First Trenton National Bank was instructed to propose three sample investment portfolios for further consideration and action.

Upon approval by the Board of Trustees of a joint recommendation of the Treasurer and the Commttee on Finance and Budget on one of these proposed portfolios, The Medical Society of New Jersey opened an investment advisory account with the Trust Division of the First Trenton National Bank on February 15, 1968. The account as of April 30, 1968 stands at $120,000.00 invested, with an approximate yield of 5.87 per cent per annum.

BALANCE SHEET, APRIL 30, 1968
GENERAL FUND

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$78,701.55	
Executive Office Revolving Account	12,500.00	$ 91,201.55
Savings Accounts:		
First Camden National Bank and Trust Co.	$15,000.00	
First National Bank of Spring Lake	15,000.00	30,000.00
Certificate of Deposit, First Trenton National Bank		15,000.00
Police Savings and Loan Association, Newark		10,000.00
Total Cash		$146,201.55
Investments—U. S. Treasury Bills (at cost)		204,938.28
Investment advisory account—First Trenton National Bank, Trustee		120,343.75
Accounts Receivable—Journal Advertising		9,214.05
Inventories:		
The Healing Art (contra)	$ 8,376.97	
Maternal Welfare Record Books (contra)	4,510.33	12,887.30
Land, Buildings and Equipment (contra)		164,453.16
Interest Accrued on Investments to April 30, 1968		3,908.69
Total Assets		$661,946.78

LIABILITIES, RESERVES AND SURPLUS

Liabilities:		
Unexpended budget—1967–68 Fiscal Year	$ 56,808.98	
Library of Academy of Medicine	23,115.00	
Payroll Deductions	923.05	
AMA Dues Collection	166.35	
Solicitation Expense—Journal	550.00	
Journal Publication	5,621.10	$ 87,184.48
Reserves:		
Assessments deferred to 1968–69 Fiscal Year	148,151.78	
Membership Directory	1,901.25	
Annual Meeting	9,858.45	
The Healing Art (contra)	8,376.97	
House Restoration and Replacement	5,370.14	
Maternal Welfare Record Books (contra)	4,510.33	
Land, Buildings and Equipment (contra)	164,453.16	
AMA Grant for Psychiatry Symposium	690.50	343,312.58
Surplus—General Fund—April 30, 1968		231,449.72
Total Liabilities, Reserves and Surplus		$661,946.78

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
GENERAL FUND

May 1, 1967 to April 30, 1968

RECEIPTS

Assessments:	*State Dues*	*AMA Dues*	*Special*	*Total*
Atlantic County	$ 6,693.44	$ 9,870.00	$ 890.00	$ 17,453.44
Bergen County	31,567.04	36,715.00	4,120.00	72,402.04
Burlington County	6,220.03	9,940.00	790.00	16,950.03
Camden County	15,266.77	24,710.00	1,955.00	41,931.77
Cape May County	1,440.00	2,310.00	180.00	3,930.00
Cumberland County	3,813.36	5,670.00	490.00	9,973.36
Essex County	61,333.65	87,885.00	7,825.00	157,043.65
Gloucester County	3,240.00	5,320.00	410.00	8,970.02
Hudson County	21,493.39	29,260.00	2,720.00	53,473.39
Hunterdon County	1,813.34	3,080.00	230.00	5,123.34
Mercer County	19,706.81	31,605.00	2,545.00	53,856.81
Middlesex County	14,480.10	23,030.00	1,845.00	39,355.10
Monmouth County	14,346.79	17,080.00	1,855.00	33,281.79
Morris County	14,660.16	22,760.00	1,915.00	39,335.16
Ocean County	4,320.04	6,790.00	560.00	11,670.04
Passaic County	22,513.47	24,360.00	2,890.00	49,763.47
Salem County	1,920.00	3,150.00	240.00	5,310.00
Somerset County	5,206.71	7,910.00	670.00	13,786.71
Sussex County	80.00	140.00	10.00	230.00
Union County	24,713.51	40,530.00	3,180.00	68,423.51
Warren County	1,746.69	2,730.00	230.00	4,706.69
Total Assessments	$276,575.32	$394,845.00	$35,550.00	$ 706,970.32

Journal advertising and other income	72,988.59
Annual Meeting Exhibits	22,973.39
Membership Directory Income	2,231.25
Interest Income	12,751.06
Sale of Maternal Welfare Books	774.23
AMA Dues Collection	3,866.15
Investments Redeemed (at cost)	508,065.26
Refunds of Budget Expenses	2,613.18
Dues Assessments Overpaid	749.43
Sales of "The Healing Art"	955.00
Accounts Receivable	1,417.89
AMA Dues Refunds	455.00
AMA Grant for Psychiatry Symposium	1,000.00
Miscellaneous Income	1,214.34
Total Receipts	$1,339,025.09
Cash Balance, May 1, 1967	252,390.33
Total	$1,591,415.42

DISBURSEMENTS

Budget Accounts:

A — 1 — Executive Salaries	$60,460.68
A — 2 — General Staff Salaries	71,269.16
A — 3 — General Executive Office Expenses	14,630.49
A — 4 — Executive Travel	2,462.63
A — 5 — House Maintenance	16,530.70
A — 6 — Treasurer	4,671.36
A — 7 — Finance and Budget	22.80
A — 8 — Secretary	17.00
A — 9 — Salary Taxes	6,207.76
A — 10 — Insurance	4,950.60
A — 11 — House Reserve	1,826.89
C — 2 — Council on Legislation	3,651.20
C — 3 — Council on Public Health	1,499.20
C — 4 — Council on Public Relations	5,426.00
C — 5 — Council on Medical Services	213.46
C — 6 — Council on Mental Health	244.54
D — 1 — President and Presidential Officers	6,825.57
D — 2 — AMA Delegates	7,912.75
D — 3 — Woman's Auxiliary	2,632.39
D — 4 — Committee on Medical Education	111.60
D — 5 — Conference Groups	13.20
D — 6 — Credentials, Membership and Directory	10,339.32
D — 7 — Emergency Medical Care	85.60
D — 10 — Project "Hope"	2,000.00
D — 11 — Medical Defense and Insurance	859.52
E — 1 — Board of Trustees	4,588.22
E — 2 — Contingent	13,985.12
E — 3 — Judicial Council	268.66
E — 4 — Legal	7,055.22
E — 6 — Medical Student Loan Fund	13,000.00

Total Budget Accounts	$ 263,761.64
Journal Publication and Expenses	79,032.19
Annual Meeting Expenses	34,380.22
AMA Dues Remitted	401,505.00
Purchases of Investments	631,564.45
Transfer to Medical Student Loan Fund	3,300.00
Dues Assessment Refunds and Overpayments	1,776.16
Library of Academy of Medicine	18,498.75
Payroll Deductions from Employees Remitted	998.47
AMA Dues Collection	3,721.50
Purchase of Maternal Welfare Record Books	4,940.76
New Jersey Sales Tax	194.43
Psychiatry Symposium	309.50
1966 History Reserve	227.09
Budget Expenditures—prior years	791.69
Miscellaneous	212.02
Total Disbursements	$1,445,213.87
Cash Balance, April 30, 1968	146,201.55
Total	$1,591,415.42

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

MEDICAL JOURNAL (Cash Basis)

May 1, 1967 to April 30, 1968

Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$54,501.58	
Advertising—Local	11,743.85	
Advertising—Classified	1,262.20	
State Medical Journal Advertising Bureau Rebate	3,723.11	
Subscriptions and Extra Copies	983.08	
Abstracts and Reprints	774.77	
Total Receipts		$ 72,988.59
Cash Disbursements:		
Publication Costs	$52,551.10	
Illustrations	110.58	
Journal Office Expenses	138.71	
Journal Travel	40.75	
Committee Meetingss and Travel	68.05	
Salaries	12,202.38	
Editor's Insurance	410.20	
Salary Taxes	677.84	
Discounts	1,311.69	
Commissions	3,063.05	
Administrative Expenses	1,225.15	
Advertising Manager—State Bureau	7,232.69	
Total Disbursements		$ 79,032.19
Excess of Disbursements over Receipts		$ 6,043.60

MEDICAL STUDENT LOAN FUND

Balance Sheet—April 30, 1968

ASSETS

Cash:		
First Trenton National Bank		
Checking Account	$ 45,533.23	
Savings Account	15,000.00	
United Savings and Loan Association, Trenton	15,000.00	
Total Cash		$ 75,533.23
U. S. Treasury Bills (at cost)		58,409.13
Notes Receivable—196 loans to 113 medical students		175,969.00
Accrued Interest on Investments		812.10
Fund Balance April 30, 1968		$310,723.46

Note—The Fund balance includes $6,312.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1967 to April 30, 1968

Cash Balance, May 1, 1967		$ 42,273.21
Receipts:		
Budget appropriation from General Fund	$ 13,000.00	
Contributions—MSNJ Special Assessments	3,300.00	
Contributions—General	4,955.00	
Contributions—Bicentennial Commemorative	600.00	
Collection on Notes Receivable	11,050.35	
Income from Investments and Savings	4,653.61	
Interest on Notes Receivable	568.49	
Investments Redeemed	176,665.90	
Total Receipts		214,793.35
Total		$257,066.56
Disbursements:		
Loans to Medical Students—5 loans	$ 5,000.00	
Purchase of Investments	176,533.33	
Total Disbursements		$181,533.33
Cash Balance, April 30, 1968		$ 75,533.23

Approved with the suggestion that the following items be incorporated in future reports: (1) Auditor's report of the previous year; (2) nature of investments and yield; (3) simplification of the report as the Treasurer may deem practical. (page 396)

Board of Trustees

Frank J. Hughes, M.D., Chairman, Camden
(Reference Committee "A")



All significant actions taken by the Board of Trustees at regular meetings held in the course of the year now closing have been reported in THE JOURNAL and have thus been called to the attention of the general membership. In addition, full copies of all Board minutes are transmitted to component societies, for reference and report at county meetings. In this report, therefore, it seems necessary and desirable to emphasize by specific mention only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

Since its last report to the House, a total of 11 meetings of the Board will have been held. Attendance of members is excellent. Dr. Louis F. Albright of Spring Lake was elected by the Board to serve as Secretary during 1967-68.

Routinely, the Board appointed representatives to local, state, and national meetings; nominated candidates to the State Board of Medical Examiners; acted on reports and recommendations of the Society's several councils and committees; and cooperated with allied organizations and state governments.

The Board, in common with the entire medical profession in New Jersey, recorded its profound grief at the untimely death of Dr. Nicholas F. Alfano, President since 1962 of Medical-Surgical Plan of New Jersey.

The Board of Trustees will have two more meetings before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report to the House.

Approved (page 394)

Joint Conference With Presidents of Component Societies

(Reference Committee "A")

The Board continued the precedent of sponsoring, in the fall and spring, informal conferences for presidents of component societies. At the urging of component societies, presidents-elect were also included this year. A total of 29 presidents and/or presidents-elect represented 18 component societies at the fall conference, and 27 presidents and/or presidents-elect represented 17 component societies at the spring conference.

The various items covered informally by this group have been reported in detail in *The Journal* and thus need not be reflected here. The Board has requested the Executive Committee to draw up proposed guidelines to outline the purpose and scope of authority of this informal group. The Board is unanimous in its agreement that sufficient meetings of the Conference of Presidents have been held to prove their effectiveness as a means of communication between the Board and presidents of component societies.

Approved (page 394)

Relief of Widows and Orphans of Medical Men

(Reference Committee "A")

The Board was reacquainted with the aims and purposes of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey. The Board reaffirmed its endorsement of the Society and commendation of it to the Society.

Approved with the following notation: There are now 1,350 members and the death benefit is $1,050 (page 394)

MSP Board of Trustees — Nominations
(Reference Committee "C")

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Not included in the list are the following: Chairman of the Board of Trustees of Hospital Service Plan of New Jersey, President of the New Jersey Hospital Association, and President of The Medical Society of New Jersey. These people serve during their respective terms of office of the organizations indicated.

Three-year term (1968-1971):

Name	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathologist	Essex County
James Crowley	Businessman	—
Lloyd M. Felmly	Retired Newspaper Editor	—
Samuel J. Lloyd, M.D.	Surgeon	Mercer County
Theron L. Marsh	Banker	—
Jesse McCall, M.D.	Internist	Sussex County
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County
Thomas J. White, M.D.	Internist	Hudson County

Two-year term (1968-1970):

Henry J. Mineur, M.D.	Internist	Union County

One-year term (1968-1969):

Donald T. Akey, M.D.	Surgeon	Middlesex County

The following persons will continue membership on the Board until the expiration of their terms in the year indicated — or until their successors are elected and qualified:

Terms expiring 1969	*Type of Practice*	*Member of Component Society*
Robert G. Boyd	Hospital Administrator	—
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cunniff, M.D.	Internist	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiologist	Monmouth County
Warren H. Simmons	Businessman	—
Sidney I. Simon, Ph.D.	College Professor	—
Robert E. Verdon, M.D.	General Practice	Bergen County

Terms expiring 1970	*Type of Practice*	*Member of Component Society*
Joseph P. Donnelly, M.D.	Obstetrician	Hudson County
Edgar P. Eaton, Jr.	Businessman	—
Joseph I. Echikson, M.D.	Internist	Essex County
Edwin T. Ferren, D.O.	General Practice	—
Mortimer J. Fox, Jr.	Businessman	—
Jerome G. Kaufman, M.D.	Internist	Essex County
Joseph M. Keating, M.D.	Obstetrician	Passaic County
Elton W. Lance, M.D.	Surgeon	Union County

Adopted (page 397)

Homemaker-Home Health Aide Project
(Reference Committee "C")

Since the 1967 annual meeting, several agencies have solicited the support of MSNJ for a demonstration project in cooperation with Blue Cross, wherein homemaker-home health aide services would be reimbursable under Blue Cross contracts. After further investigation, the Board reaffirmed its previous decision that it could not endorse the project. However, inasmuch as the Board's action in rejecting endorsement of this project was reported to — and approved by — the 1967 House, the Board directed that the entire matter be returned to the 1968 House of Delegates for reconsideration at its discretion.

Approved to estimate the effectiveness and usefulness of Homemaker-Health Aide in Hospital utilization (page 397)

Blood Insurance Program
(Reference Committee "C")

The 1967 House (Resolution #24 — Passaic County) called upon the AMA to urge labor unions in their health care negotiations "to insure their blood needs by a blood insurance program rather than through a financial insurance benefit." New Jersey's delegation introduced and supported a resolution (#38) at the AMA annual meeting. It was the opinion of the AMA reference committee to which it was referred that the intent of the resolution was to reaffirm AMA policy in the provision of blood for transfusions. The AMA House adopted a substitute resolution, which reaffirmed AMA policy, opposing in principle the payment for whole blood and red blood cells through insurance.

Approved (page 397)

AID Program
(Reference Committee "C")

In cooperation with the Permanent Committee on Blue Cross-Blue Shield, the Board approved (1) a list of recommended extended maximum limits of stay for certain of the listed diagnoses on AID, with supporting statistical background; and (2) a list offering new diagnoses and durational maximums not thus far included in the AID schedule.

Approved (page 397)

Physicians' Fees Under OCHAMPUS
(Reference Committee "C")

Approval was given to the Office of the Surgeon General to convert payments to the basis of usual, customary, and reasonable fees for services rendered by New Jersey physicians under OCHAMPUS and to discontinue payments on the basis of the Schedule of Maximum Allowances, effective December 1, 1967.

Approved (page 397)

JEMPAC
(Reference Committee "E")

The 1967 AMA House urged that leaders and members of local organizations continue support of their own state PAC organization (JEMPAC) as well as AMPAC. The Board reiterated its encouragement of members, as individual physicians, to join and support both JEMPAC and AMPAC. The Board authorized the establishment of a conference committee with JEMPAC to improve communication and exchange of ideas.

Approved, urging the membership to give strong support to JEMPAC and AMPAC (page 399)

Payments of Interns and Residents
(Reference Committee "F")

The 1967 House (Resolution #10 — delegate from Hudson County) called upon the AMA to reaffirm its support of the principle presently embodied in the Medicare Law (Title XVIII) whereby payment of interns and residents under Part B is excluded. It was directed that official representatives and agencies of the American Medical Association take cognizance of this position and be consistently and exclusively guided thereby to the end that no circumvention of this policy be indulged or encouraged. A resolution (#98) was introduced and supported by New Jersey's delegation at the AMA meeting. The reference committee to which it was referred declared: "Resolution #98 reaffirms Associa-

tion policy on the compensation of hospital staffs . . . Your reference committee believes that the adoption of this resolution would be redundant and, therefore, recommends that it be not adopted." In rebuttal from the floor of the AMA House, New Jersey pointed out that reaffirmation was necessary and desirable in order to put all members of the profession and all agencies of the AMA on notice. In a voice vote, following supporting speeches from the floor, the AMA House rejected the recommendation of the reference committee and adopted the resolution.

Approved (page 402)

Health Facilities Planning Council
(Reference Committee "F")

The Health Facilities Planning Council solicited contributors from non-government sources to support its 1968-1969 program. The Board pledged a $5,000 contribution, with the understanding that the Society's support of the council is contingent upon the organization's remaining a voluntary association, with its findings and recommendations continuing as advisory and not controlling.

Approved with emphasis on the following portion of the report:
That the Society's support of the Council is contingent upon the organization's remaining o voluntory ossociotion, with its findings and recommendations continuing os odvisory ond not controlling (poge 402)

Generic Versus Proprietary Drugs
(Reference Committee "F")

The 1967 House (Resolution #9 — Essex County) declared that the treating physician should have the choice (in all private paid, insurance paid, and government paid programs) in deciding whether or not to prescribe generically or by brand name and called upon the AMA to support the policy of freedom of choice of drugs by the physician in order to enable him to best serve his patient. The New Jersey delegation accordingly introduced and supported Resolution #37 in the AMA House. Three similar resolutions were also offered to the AMA House. The reference committee to which all four were referred proposed — and the House adopted — a substitute for them, directing that the AMA again reaffirm its policy that physicians should be free to use either generic or brand names in prescribing drugs for their patients; and encouraging physicians to supplement medical judgements with cost considerations in making their choice.

Approved (page 401)

Heart Disease, Cancer, and Stroke
(Reference Committee "G")

Dr. Joseph R. Jehl, as Chairman of the Board of Trustees of the New Jersey Joint Committee for Implementation of Public Law 89-239 (heart disease, cancer, and stroke federal legislation) kept the Board informed of the activities of this regional program. A revised application for a planning grant for a New Jersey program was approved for the first year for approximately $297,000. The New Jersey College of Medicine and Dentistry was designated as the fiscal agent for the expenditure of this money.

Approved (page 405)

Smoking in Hospitals
(Reference Committee "G")

The New Jersey Hospital Association sought the Society's position regarding the effects of tobacco on health, to utilize the information in recommending that member-hospitals make every effort to discourage smoking on their premises by patients or employees. Because of the mounting evidence of the injurious effects of tobacco on humans, the Board voted to support the recommendation that no form of tobacco be sold in hospitals of New Jersey.

Approved with the following suggestion:
Thot MSNJ take o vigorous stand ogainst oll forms of tobacco. (poge 405)

Diploma Schools of Nursing
(Reference Committee "H")

The Board unanimously endorsed as the policy position of MSNJ a resolution adopted by the AMA House in June 1967, declaring that:

1) the AMA reaffirms its support of all forms of nursing education including baccalaureate, associate degree, diploma, and practical nurse education programs;

2) those hospitals that conduct diploma schools of nursing be commended for their great contribution to the satisfaction of the health needs of the nation;

3) such hospitals be urged to continue their schools and to increase enrollment, while allowing the individual to choose the kind of nursing education he or she desires;

4) the AMA take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time to improve educational standards.

Approved (page 407)

Supplemental Report #1

As the result of its April 21 meeting, the Board of Trustees directed several items to the attention of the 1968 House of Delegates. Thus does the Board submit this Supplemental Report #1, which has been compiled since the preparation of the annual report.

The Board is scheduled to meet next in Atlantic City prior to the opening session of the House. The results of this meeting will be the basis for Supplemental Report #2 to the House, to bring the members up to date on relevant items.

Professional Liability Panel
(Reference Committee "A")

The Administrative Director of the Courts has rendered a summary report as of March 13, 1968, indicating the Courts' experience in handling claims under the Supreme Court Rule 4:25B (concerning the use of subpanels on professional liability claims).

	1966	*1967*	*1968*
Number of claims filed	35	51	7
Number of doctors involved	51	68	11
Number of subpanel hearings	21	20	
Result of subpanel hearings			
Reasonable basis	7	5	
No basis	15	15	
Number of refusals by doctors for subpanel hearings	9	8	1
Number of claims withdrawn	4	7	
Number pending as of March 13, 1968	1	16	7

The Board recorded its gratification with these results as well as continued indications that the program has generated national attention and interest. For these reasons, the Board directed that the foregoing information be referred to the House, together with the following recommendation:

Recommendation

That the medical malpractice claims panel program be continued and that the members of MSNJ be encouraged to continue to cooperate in its furtherance.

Approved (page 394)

Project Hope
(Reference Committee "B")

In reporting to the 1967 House of Delegates, the Board of Trustees recommended — and the House approved — "that the six fellowships created by the 1966 House of Delegates — to be awarded on a pilot basis for one year, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the *S.S. Hope* or her sister-ship — be extended on an experimental basis for one more year (1967-1968)."

During the past year, the Board approved the granting of three Project Hope fellowships.

The Board is of the opinion that this project is one that will prove its value in time. It is for this reason that the Board has concluded that the "pilot basis" condition of this project should be ended and the program should be made a continuing project.

The Board recognized, however, that many physicians are volunteering for non-remunerative service in Vietnam and that the requirements for such service are not as variable and,

therefore, are not as restrictive as Project Hope. For these reasons, the Board is of the unanimous opinion that the applied intentions of Project Hope should be broadened to include voluntary service by physicians in Vietnam.

Recommendation

That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a "first-come, first-served" basis, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the *S.S. Hope,* her sister-ship, or voluntary service in Vietnam.

Approved (page 396)

MSP Board of Trustees Composition
(Reference Committee "C")

In approving MSP nominations to its Board of Trustees, the 1967 House of Delegates made the following suggestions to Medical-Surgical Plan of New Jersey:

1. That the number of terms to be served by the Trustees of MSP be limited.

2. That efforts be made to secure "new blood" in the organization and that major changes should not be made primarily because of the death or resignation of a member of MSP Board of Trustees.

3. That MSP Board consider the desirability of receiving nominations of physicians for membership on its Board from the Nominating Committee of MSNJ.

At its meeting on April 21, the Board of Trustees received the following detailed report from Medical-Surgical Plan of New Jersey, which is directed to the attention of the 1968 House of Delegates:

The MSP Board of Trustees Nominating Committee, after discussing each of these suggestions at length, recommended — and the MSP Board of Trustees approved — that MSNJ be advised as follows:

1. It requires five to six years for a new Trustee to become thoroughly familiar with the Plan's operations. The ensuing years are the most fruitful in terms of a Trustee's capacity for contributing.

2. Had the composition of the Board remained static, the criticism implied by the suggestion for "new blood" would be justified. It is, however, a matter of record that seventeen of the current twenty-four elected members of the Board have been elected during the last 10 years. In considering renominations, such factors as interest and attendance rather than tenure are carefully weighed by the Nominating Committee.

3. Suggestions as to nominees to the MSP Board of Trustees from the Board of Trustees of MSNJ will be welcomed. However, making nominations to the MSP Board of Trustees is not within the purview of the Nominating Committee of MSNJ. Furthermore, such an arrangement might reactivate the criticism that led to the Supreme Court action which declared unconstitutional that portion of the Plan's enabling legislation requiring approval of the Plan's Trustees by MSNJ.

Approved (page 397)

MSP Prevailing Fee Program
(Reference Committee "C")

The 1967 House of Delegates — in approving a Prevailing Fee Program for experience-rated national accounts which desire such a program — stated that "the entire situation should be reviewed by the House at its next annual meeting in 1968, for the purpose of critical evaluation in the light of the year's experience."

At its April 21 meeting, the Board of Trustees received the following detailed report from Medical-Surgical Plan of New Jersey, which is directed to the attention of the 1968 House of Delegates:

It should be pointed out that the Plan's usual, customary, and reasonable charges program — known as the Prevailing Fee Program — did not become effective for the initial groups enrolled thereunder until August 1, 1967. Hence it has been in effect less than nine months as of this date. It is not yet fully operational — although claims for eligible services rendered on and after August 1, 1967, have been and are being paid on a Prevailing Fee basis — due primarily to the failure of many physicians to enroll as Participating Doctors. Unforeseen operational problems within the Plan have been a further delaying factor. These aspects are dealt with further on.

This report, since it cannot reflect a year's experience of Prevailing Fee, addresses itself

to those developments in connection with Prevailing Fee which have taken place since the meeting of the 1967 House of Delegates.

At that time more than 9,000 doctors and laboratory directors had been surveyed by the Plan concerning their usual charges. By the end of May 1967 about 4,500 (or 50 per cent) had responded. A follow-up letter with duplicate Survey forms was sent to non-respondents. By August over 6,000 responses had been received, and this number has slowly increased since.

As a result of our March 1967 Survey, over 190,000 specific fees were recorded. From these, the range of charges by specialty and by geographic area was determined. The 90th percentile for each fee was computed, which for some services was just above 90 per cent, while for others it included over 98 per cent of all the fees filed.

Using the individual survey replies as modified by the ranges determined from all the surveys, a Personal Schedule of Fees was prepared and mailed to each respondent. Many computer problems delayed this phase of the program far beyond our desires. The mailing, therefore, was not made until late February and early March of this year.

To date over 40 per cent of these Personal Fee Schedules have been returned to the Plan with signed Special Participating Agreements for this program. Since the objective of Prevailing Fee is to assure payment in full of at least 90 per cent of the claims submitted thereunder, more than double the present physician participation is needed to enable full implementation of the program.

A temporary procedure was instituted for paying claims eligible under Prevailing Fee for services rendered on and after August 1, 1967. Initial payments were made under the Plan's Series 500 Fee Schedule, with notification to the physician and subscriber that a supplementary payment – bringing the total to Prevailing Fee levels – would be made subsequently. As soon as Prevailing Fee ranges were established, these supplementary payments were begun to physicians who had filed Surveys. In all, over 1,000 Prevailing Fee claims were paid by this method through April 10, amounting to $73,000. Prevailing Fee claims are now being paid directly from physicians' Personal Fee Schedules.

Slow response to the Plan's invitation to participate in Prevailing Fee is a matter of grave concern to the Plan, and should be, as well, to the physicians of New Jersey.

At stake is the future of the entire Prevailing Fee concept in New Jersey and Blue Shield's capability to provide payments based upon physicians' usual, customary, and reasonable charges. This relates not only to the initial subscriber enrollment under Prevailing Fee, but also now applies to the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), whose beneficiaries throughout the State include dependents of active duty personnel, retirees, and their dependents. It is also scheduled to become the basis of payment for the Federal Employee Program (with 119,000 New Jersey members) and for the Motors industry (with 108,000 New Jersey members) by the last quarter of 1968.

Thus, nearly a quarter million additional Blue Shield members are due to come under Prevailing Fee in the next few months. In addition, the Plan has received indications of interest in Prevailing Fee from a number of other accounts, and currently has under study an approach for providing this coverage on a wider basis.

In view of the foregoing, Medical-Surgical Plan respectfully and urgently solicits the full approval of MSNJ for the Plan's Prevailing Fee Program and its active support in obtaining further participation by its members to enable full implementation of the program –which will be to the mutual advantage of the subscribing public, the medical profession, and the Plan.

Approved (page 397)

Payments for Services of Hospital-Based Specialists

(Reference Committee "C")

Resolution #15 — adopted by the 1966 House of Delegates — called upon MSNJ to urge Medical-Surgical Plan of New Jersey to contact the Hospital Service Plan of New Jersey, to effect the inclusion of hospital-based professional medical services within the contracts of MSP and the exclusion of such services from the contracts of HSP, with as little as possible inconvenience or cost to the Plans' subscribers. The resolution also called upon MSP to report to the MSNJ Board concerning its progress toward attainment of this end.

At its April 21 meeting, the Board of Trustees received the following report from Medical-Surgical Plan of New Jersey, which is directed to the attention of the 1968 House of Delegates:

The problem of coverage by the Blue Plans for services of hospital-based specialists has been under study and discussion for nearly two years by MSP and our companion Blue Cross Plan, HSP, and the Radiological Society of New Jersey. To date, no practical solution has been found.

The crux of the problem is best seen in the case of the radiologists. It may be found in three areas: (1) Services of such hospital-based specialists, until recently, have been rendered as hospital services and thus are included in the hospital services provided under the Blue Cross Subscription Certificate. Hence, such services represent a portion of the Blue Cross premium charged subscribers under the certificate. Blue Shield, on the other hand, specifically excludes coverage of such services under its Subscription Certificate and hence no premium is charged its subscribers to underwrite such services. (2) There is no uniformity in the practices followed by New Jersey radiologists in regard to charging on a fee-for-service basis or maintaining salary or other contractual arrangements with hospitals. (3) The Radiological Society delayed until recently providing the Plans with data to undertake a study of the problem, and such data as were supplied at that time were not meaningful in indicating any possible solution.

In an effort to implement the spirit of the resolution adopted by the House of Delegates, as well as the policy affirmed by the American Medical Association (i.e., that the professional component of radiology is a medical service for which a radiologist may bill his patient), the MSP Fee Committee, after exhaustive study, made the following recommendation, which was approved by the Plan's Board of Trustees:

> That the Plan act as the fiscal agent of Hospital Service Plan of New Jersey for payment of professional component for radiology, provided that Blue Shield subscriber funds are not utilized and further providing that a plan for such payments is mutually acceptable to the Radiological Society of New Jersey and the Hospital Service Plan of New Jersey.

This approach was suggested by the Radiological Society, and appears to indicate that the Society has recognized the inherent difficulties in transferring benefits from one Plan to the other because of differences in subscriber population makeup. Even if a shift of benefits were otherwise feasible, the lack of uniformity among radiologists in their billing procedures precludes such an approach.

Negotiations with the Radiological Society were still in progress in late January 1968, when that Society requested its members, who are on fee-for-service and had been billing the hospital for Blue Cross patients, immediately to start sending bills directly to Blue Cross for services rendered (and, if not paid for within 10 to 20 days, to bill the patient). This procedure, of course, is unacceptable to the Plans, and was declared unacceptable by the MSNJ Board of Trustees in a letter to the Radiological Society. Following this unilateral decision by the Radiological Society, there has been no progress toward the development of a plan that would be mutually

acceptable to Blue Shield, Blue Cross, and the Society.

Medical-Surgical Plan assures the Board of Trustees and the membership of MSNJ that it will continue to explore every avenue which might lead to a solution of this complex problem that would be equitable and agreeable to all of the parties concerned.

Approved (page 397)

Blue Cross-Blue Shield "65" Program
(Reference Committee "C")

At its April 21 meeting, the Board of Trustees received the following report from Medical-Surgical Plan of New Jersey, which is directed to the attention of the 1968 House of Delegates:

The 1967 House of Delegates approved the Plan offering an extended benefits Rider, similar to Rider J, to provide additional coverage for out-of-hospital diagnostic, therapeutic, and surgical services to subscribers enrolled under the Blue Cross and Blue Shield "65" program, which complements Medicare Part B for in-hospital services only.

Projection of a premium for such a Rider was not feasible while major amendments to Title XVIII were under consideration by the Congress. For example, the eventual inclusion of podiatrists' services as eligible under Part B of Medicare, which dictates the inclusion of such services in the Rider, proved a major factor to be considered in projecting utilization under the Rider, and hence the premium necessary.

These calculations are now being completed, and the Rider will be submitted shortly to the Department of Banking and Insurance. The Plan expects to be informed of the Department's approval or disapproval prior to the 1968 meeting of the House of Delegates, and will inform the Board of Trustees of MSNJ of the Department's determination as soon as received.

Approved (page 397)

External Cardiopulmonary Resuscitation
(Reference Committee "G")

The New Jersey Heart Association Cardiopulmonary Resuscitation Committee urges that MSNJ and the New Jersey Hospital Association concur in a revised statement on cardiopulmonary resuscitation adopted by the New Jersey State Nurses' Association. It is the opinion of the Heart Association committee that the revisions to the original statement "are valid and reasonable."

Since the original statement was approved by the 1967 House of Delegates, the Board referred the revised statement to the 1968 House for its action:

External Cardiopulmonary Resuscitation (Including Defibrillation) And The Registered Professional Nurse

The procedure of external cardiopulmonary resuscitation (including defibrillation) is primarily a medical procedure and, therefore, the policy of delegating this responsibility in an emergency situation to a properly qualified registered professional nurse must be established by the medical board of the individual hospital or other comparable agency.

In an emergency situation — and in the absence of a physician and until a physician arrives — a registered professional nurse, certified as properly qualified in the technique by the medical board of the individual hospital or some other comparable agency, may initiate the procedures of external cardiopulmonary resuscitation (including defibrillation) provided that the RN would thereby be acting in accordance with established policy.

Where a hospital has established a policy that a registered nurse may perform the techniques of external cardiopulmonary resuscitation (including defibrillation)—the techniques to be performed, the criteria for certification, and the area of practice for the individual nurse shall be established for the hospital by a committee from the medical staff, the department of nursing, and the administration.

To assure that registered professional nurses remain properly qualified to carry out the procedures, hospitals and agencies should provide continuing training programs on external cardiopulmonary resuscitation (including defibrillation) under the direction of a physician officially designated.

These established policies, procedures, and definitions of roles, authority and responsibility of the nurse, as well as other members of the resuscitation team, should be in writing and made available to the total medical and nursing staffs.

Approved (page 405)

Supplemental Report #2

The Board of Trustees held its final meeting for the fiscal year 1967-68 on Friday evening, May 17. The following items from that meeting are directed to the attention of the House.

AID Program

(Reference Committee "C")

The Permanent Committee on Blue Cross-Blue Shield unanimously reaffirmed its conviction that the AID Program is an effective instrument, when efficiently used, for safeguarding proper hospital utilization. It is the Committee's opinion that the reaction against the AID Program has been largely attributable to unsatisfactory methods of effectuation of the program. The Committee holds that it is the responsibility of hospital administration to supply adequate, competent assistance to the utilization committee in order to support and sustain the AID Program.

The Board strongly seeks and solicits the support of physicians and hospital administrators alike, to the end that the AID Program may continue to realize its purpose of helping to guard against over-utilization. The Board approved the following recommendation of the Permanent Committee to hospital administrators and medical staffs:

Recommendation

That a flag notice be put on the chart no less than 48 hours in advance of the estimated AID time for a given patient's discharge. If physicians thus alerted certify when certification is indicated, there will be no problem centering about delinquent certification.

Approved with the following recommendation: That the AID program be under continual review to improve its operation. (page 397)

Therapeutic Abortion

(Reference Committee "G")

Early in 1968, the Board of Trustees authorized a survey of the members to determine individual positions with reference to the policy statement on therapeutic abortion adopted by the House of Delegates of the American Medical Association in June 1967.

A total of 7,524 survey ballots were mailed. As of April 15 (the deadline for tabulation) 4,348 had been returned. The achieved response, therefore, was 57.8 per cent. One hundred eighty ballots could not be tabulated because of internal inconsistencies.

Answering Part I of the ballot, 501 members indicated that they favored retention of the present New Jersey precedents of recognizing as legally permissible only an abortion performed to save the life of the mother; 3,667 members indicated that they disapproved of such retention.

Answering Part II of the ballot, members indicated approval of the five numbered sections as follows:

Section 1	3,654	(87%)
Section 2	3,541	(85%)
Section 3	3,666	(88%)
Section 4	3,603	(86%)
Section 5	3,582	(86%)

Overwhelmingly, therefore, the survey shows that a strong majority of MSNJ members favor the AMA Policy Statement. Accordingly, the Board of Trustees — with the concurrence of the Special Committee on Maternal and Infant Welfare — makes the following recommendation.

Recommendation

That the House of Delegates of The Medical Society of New Jersey affirm and adopt as its own the policy statement adopted by the AMA House of Delegates in June 1967; to wit:

. . . Recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any circumstances, The Medical Society of New Jersey is opposed to induced abortion except when:

(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

(3) There is documented medical evidence that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient,

(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing, and

(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Approved with the following suggestion: That, in protection of physicians who on moral or religious grounds prefer not to perform abortions, legal immunity be sought and established. (page 405)

Academy of Medicine of New Jersey
(Reference Committee "B")

In approving the $5 per capita assessment for postgraduate educational programs of the Academy, the 1967 House recommended that the Academy make known to the membership details of all postgraduate facilities which are offered. The Academy submitted the following financial statement for the 1967-68 academic year. The schedule of its activities in the educational field have been regularly published in *The Journal* throughout the year.

INCOME:

Academy Dues	$31,848
The Medical Society of N. J.	31,000
Other Grants & Donations	16,215
Specific Meetings	14,560
Library Income	13,615
Bulletin Income	1,625
Dividends & Interest	557
Miscellaneous	700
TOTAL INCOME	$110,120*

EXPENSES: Education

Salaries & Wages	$18,292
Overhead	6,985
Meetings & Programs	23,962
Bulletin Expense	11,338
	$60,577

EXPENSES: Library

Salaries & Wages	$21,696
Overhead	8,265
Books & Periodicals	9,090
Photoduplication	2,075
Binding	2,310
Medical Library Center of N. Y.	1,740
	45,176
TOTAL EXPENSES	$105,753**

*$27,500 income uncollected 5/15/68
**$12,972 accounts payable 5/15/68

Approved with the following suggestion: That there be at least two month's advance notice of programed meetings. (page 396)

Dr. Allman To AMA Legislative Council

David B. Allman, M.D., Brigantine, has been reappointed to the AMA Council on Legislative Activities. This Council reviews all proposed federal legislation and recommends AMA action; recommends changes in AMA policy when necessary to accomplish effective legislative goals; acts as a reference council to which *all* legislative issues of the Association are channeled; maintains constant surveillance of the legislative scene; anticipates future legislative needs; and recommends to the AMA Board of Trustees new federal legislation as well as legislation to modify exisiting laws of interest to the Association.

Judicial Council

E. Vernon Davis, M.D., Chairman, Mount Holly
(Reference Committee "A")



Apart from its work as an appellate tribunal considering matters originally dealt with by county judicial committees, the Judicial Council has responsibility under the bylaws to supervise, direct, and keep records of all complaints dealt with by county judicial committees as matters of original jurisdiction. To accomplish this function, the Council — with the cooperation of county judicial committees — receives reports of all complaints accepted by county judicial committees and the dispositions made of them.

From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from April 1, 1967 through March 31, 1968:

By Judicial Committees

Complaints reported as disposed of	22
Alleging:	
Dissatisfaction concerning fees	10
Unethical conduct	5
Dissatisfaction with services rendered	4
Unprofessional conduct	3

By the Judicial Council

Meetings held	6
Official communications acted upon	9
Appeal hearings requested	6
granted	2
Formal opinions rendered	1

Ethical acceptability of the executive diagnostic programs proposed by a local hospital.

The foregoing opinion is presented in full as an appendix to this report.

The above figures seem to indicate a sizeable decrease in the number of complaints processed by county judicial committees. It can be concluded that the record indicates fewer dissatisfactions concerning the ethical and/or professional conduct of our members. For this improved cooperation, the Council is grateful. Judicial committees functioning at county level have been able to settle most grievances to the satisfaction of those concerned. This is evidenced by the fact that only two appeal hearings from their decisions have been necessitated.

The Judicial Council urges that those county judicial committees which may not have extended full cooperation now do so, in the interest of efficiency of the entire judicial mechanism, satisfaction of the public, and protection of our members. It is a disservice to members as well as to the general public if county judicial committees do not function promptly and dependably.

It is the Council's experience that the commonest complaint concerns fees or the misunderstanding of what was to be expected in the treatment of a patient. Wherever possible, it would seem wise to have a clear understanding between physician and patient regarding these considerations before treatment is undertaken.

The Council takes this opportunity to emphasize that decisions of judicial committees of component societies are binding upon all members. The judicial committee of each component society, in the enforcement of its findings duly arrived at, has the power to censure, suspend, or expel any member of its society for just cause.

There has been generally a favorable reaction to MSNJ's efforts to assure the public that we

do not condone professional misconduct and are not in sympathy with those members who ignore their responsibilities. While judicial committees act primarily in the public interest, they also serve to keep the physician's record clear among his colleagues when he has been unjustly accused.

Opinion

ETHICAL ACCEPTABILITY OF THE EXECUTIVE DIAGNOSTIC PROGRAMS PROPOSED BY A LOCAL HOSPITAL

On the basis of information before it, it was the Council's understanding that the Executive Diagnostic Program would be administered by physicians who volunteered to take part in the program, using hospital facilities; individual physicians would bill for services rendered, reimbursing the hospital for facilities used. The Council was informed that the procedure has already been approved by the American Medical Association, the American College of Surgeons, and the Joint Commission on Accreditation of Hospitals.

Under the circumstances outlined above, it was the unanimous opinion of the Judicial Council that it could find nothing unethical about the program.

Approved (page 394)

Chairmen Councils and Committees 1968-1969

Air Pollution
Roslyn Barbash, M.D., Teaneck

Alcoholism
Henry J. Mineur, M.D., Cranford

Annual Meeting
Jerome G. Kaufman, M.D., Maplewood

Cancer Control
John L. Olpp, M.D., Englewood

Child Health
William J. Farley, M.D., Nutley

Conservation of Vision
Frank B. Vanderbeek, M.D., Paterson

Credentials
Marcus H. Greifinger, M.D., Newark

Drug Addiction
Henry A. Davidson, M.D., Cedar Grove

Judicial
Albert F. Moriconi, M.D., Trenton

Emergency Medical Care
Jack R. Karel, M.D., Hillside

Emotional Disorders of Childhood and Adolescence
Eugene V. Resnick, M.D., Paramus

Finance and Budget
Thomas C. DeCecio, M.D., Cliffside Park

Honorary Membership
Ralph M. L. Buchanan, M.D., Phillipsburg

Legislation
Jesse McCall, M.D., Newton

Maternal and Infant Welfare
John D. Preece, M.D., Trenton

Medical Defense and Insurance
Fred A. Mettler, M.D., Blairstown

Medical Education
Louis F. Albright, M.D., Spring Lake

Medical Services
Louis K. Collins, M.D., Glassboro

Medical Student Loan Fund
Frank J. Hughes, M.D., Gloucester

Medicine and Religion
Luke A. Mulligan, M.D., Leonia

Mental Health
Robert S. Garber, M.D., Belle Mead

Mental Retardation
Miles E. Drake, M.D., Vineland

Occupational Health, Workmen's Comp. & Rehab.
Joseph A. Lepree, M.D., Elizabeth

Project Hope — Vietnam
Thomas C. DeCecio, M.D., Cliffside Park

Publication
George B. Sharbaugh, M.D., Trenton

Public Health
John P. Coughlin, M.D., Jersey City

Public Relations
John J. Crosby, M.D., Jersey Cty

Retirement Plan for Physicians
Nicholas E. Marchione, M.D., Vineland

Revision of Constitution and Bylaws
John J. Thompson, M.D., Caldwell

Seizures
J. Lloyd Morrow, M.D., Passaic

Traffic Safety
Irwin S. Smith, M.D., Willingboro

Woman's Auxiliary Advisory
George O. Rowohlt, M.D., Dumont

Executive Director

Richard I. Nevin, Trenton
(Reference Committee "A")



The period of the Annual Meeting serves as a sort of time plateau at which we pause in our climb toward the summit of our objectives. We have come far in our pilgrimage together. At this juncture we pause to weigh the experiences through which we have just passed, and to plan the next phase of our activities.

It is as important as it is gratifying to note that many of the problems that confronted physicians of earlier times — problems centering about the treatment of disease and the preservation of health — no longer challenge us. Scientific research and increasing knowledge and skills enable the men and women of medicine of today successfully to treat and to conquer innumerable disease conditions against which once the profession was helpless. So sure is the power of modern medicine to treat and overcome diseases which formerly brought early death or handicapped living to many that now health and long life are no longer regarded as a fortunate providential dispensation for a lucky few, but as the right of all. Government has so declared. It is pledging itself increasingly to underwrite the cost of comprehensive health care services that will make those benefits available to all. The two chief problems of medicine today arise, first, out of the difficulty of trying to insure good health and long life to all equally, without regard to individual limitations and disadvantages; and, second, out of the twin challenges of limited health-care manpower and inadequacy of available funds.

In the year now ending, we of The Medical Society of New Jersey have strongly urged the necessity for increasing the number and productivity of medical schools in New Jersey. We have supported governmental financial assistance to refresher courses for graduate nurses, as well as to all programs of nursing education—baccalaureate and associate degree programs, diploma schools, and practical-nurses training programs. We have supported a bill to permit a candidate to qualify in New Jersey for examination for licensure as physician and surgeon on the basis of declaration of his intent to obtain American citizenship, instead of requiring actual citizenship as a prerequisite. That bill is now before the Governor for signature. Likewise we have caused to be introduced in the State Legislature a bill to afford legal protection to certain qualified individuals rendering limited ancillary assistance to a licensed physician in the care of his patients. . . . All these measures we have embraced as means of decreasing to some extent our manpower shortages.

Likewise we have urged the establishment of a fair, sound, and comprehensive Medicaid Program in New Jersey, as a means, at least, of adequately financing necessary health-care for citizens unable to underwrite their own expenses. The chief impediment to this program seems to be the lack of sufficient state funds to permit the establishment of the program on an adequately broad basis to provide help for all those in straitened circumstances. The Society's official statements in this connection are a matter of record.

The foregoing are but a few instances of activity this year in one area of concern. The monthly minutes of our Board meetings and the annual reports of all our councils and committees combine to reflect with accuracy the broad and sweeping scope of all our activities as a Society in the course of the year now closing.

It has been a year intensely paced and encouragingly fruitful. Doctor Collins gave to us all a splendid example of knowledgeable and competent leadership—an example which all the other officers, council and committee chairmen and members were quick to follow, with great benefit to the entire Society.

It has been a year, staff-wise, of changes and adaptations. Early in the year — as of August 30, to be exact — Mr. George Degnon resigned to take a position on the staff of the American Academy of Pediatrics. As of September 25, he was succeeded as Executive Assistant to the Executive Director by Mr. Vincent A. Maressa, recently graduated from the Law School of Temple University with the degree of Doctor Juris. Early in the Fall, Miss Theresa E. Goeke submitted her resignation as Executive Assistant to the Executive Director, to be effective in the first week of June, 1968.

Thus, Miss Goeke's long and outstanding service to the Society will terminate shortly after the close of this administrative year. Through the years since her coming to the Society in 1951, Miss Goeke has made progressive contributions to our staff operations. We shall all miss her very much. We wish her well in her future travels and subsequent endeavors.

Mrs. Diana Brugger has become the Secretary to the Executive Director and has been working in tandem with Miss Goeke on the business of the House of Delegates, the Board of Trustees, and other specified areas of concern. Mrs. Arlene Warner was added to the staff as a Secretary in early March, to understudy and ultimately to be responsible for Miss Goeke's work with the Council on Legislation, the Council on Public Relations, and the Judicial Council. Mrs. Phyllis Chrismer has been named Supervising Secretary for the office operations presided over by Mr. Maressa.

We face the administrative year of 1968-1969, therefore, with a modified team lineup. We have the demonstrated abilities and loyalties of all our other staff members to give us confidence that all will be well. We shall do all in our power to insure that it will be so.

Confronted by flux and change, within and without, I have not been idle or free from care. In addition to my routine responsibilities, my diary records that I have participated in some 180 meetings and conferences of all kinds, visited 11 component societies, made 11 formal speech presentations, and made one visit out-of-state — to the AMA Clinical Convention in Houston. As a matter of fact, because I was so busily involved in our own office activities, I found it necessary to forego a number of out-of-state meetings which normally I would have attended. However, the Society was well represented by officers and council and committee chairmen designated by the Board.

Perhaps there have never been more turbulent and perilous times for our country than those in which we find ourselves. There is no greater threat to a nation than the progressive deterioration of the character of its people. The elemental crises that grip us, the deepening issues that divide us, the rampant self-seeking of individuals and the flagrant disregard of the public good that prevail, the disrespect for authority, the contempt for life and property, the tolerance of and sharpening appetite for violence, the contempt for virtue, and the indulgence of vice — all pose for us questions as to the state of our health as a people and a nation that far transcend in importance concern for the physical and mental health of individuals.

The Medical Society of New Jersey is made up of men and women dedicated to the advancement of health and the general welfare. Never has that dedication called for greater or more sacrificial idealistic devotion. May we find together the great qualities of mind and heart necessary to meet the challenges which are ours. We must work as though life depended upon our success, because — whether the service we render is to individual patients or to our country — as a matter of fact, it does!

Approved (page 394)

Annual Meeting

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "H")



The committee met in June and again in September 1967, to develop plans for the 1968 meeting, in accordance with referrals from the 1967 House of Delegates and from the Board of Trustees.

In an effort to avoid conflicting sessions during the convention, the Board directed that the committee consider possible rearrangement of the times of the address of the outgoing President; the inauguration of the incoming President; Nominating Committee meeting; and the scheduling of the meetings of the Reference Committees.

The Board of Trustees will meet at 4:00 p.m., Friday afternoon, and it is generally felt that all business can be completed by 7:00 p.m., thereby eliminating the necessity of reconvening following dinner.

The 1968 schedule for the sessions of the House will be the same as in 1967 — 1st session on Saturday; 2nd session on Sunday; and 3rd session on Tuesday. Haddon Hall's new Windsor Room has been reserved for all sessions of the House, and all sessions will be seated in schoolroom setup, by district, by county.

The time of the Golden Merit Award Ceremony will be advanced an hour in order that the 1st session of the House and the President's farewell address can be scheduled for 3:00 p.m. This session will be followed by the Open Discussion on Medical-Surgical Plan. The Nominating Committee will meet at 4:30 on the afternoon of the first day of the annual meeting, rather than in the evening following the Officers' Dinner. The 2nd session of the House (election) will be held at 2:30 on Sunday afternoon, immediately preceding the inaugural address of the incoming President (General Session). In compliance with a Board directive, the president of component societies will be invited to participate in the inauguration ceremonies this year.

The Inaugural Reception will be held on Sunday evening, and will be open to all registered members and official invited guests. Admission to the Reception will be by badge. The Annual Dinner-Dance, honoring the President, is scheduled for Monday evening. Tuesday evening has been reserved for the reception honoring technical exhibitors, and the invitation list will include technical exhibitors, Trustees, and Officers.

The advance program was mailed in February to the membership, all New Jersey, Philadelphia, and New York City hospitals and medical schools, and to editors of journals of nearby state medical societies.

Last year, the Board authorized the purchase of several steamer-type trunks for use in connection with transporting annual meeting materials to and from Atlantic City. However, it was not possible to locate the type trunk desired. Therefore, the committee contracted for tiered, wooden packing cases, made to specification, and they will be in use for the 1968 meeting.

Ninety-nine exhibits — technical, scientific, and informational — will be presented this year. In addition to the exhibits, the Prudential Insurance Company of America will sponsor the Coffee Lounge; and the New Jersey Medical Assistants Association, Inc. will

"man" the Message Center. These two features and all exhibits will be housed in the Exhibit Hall. Exhibits will open at noon on Sunday; remain open all day Monday and Tuesday; and close at noon on Wednesday.

In the hope of stimulating the flow of traffic through the exhibits, the Board approved a suggestion that attendance awards of $100, $50, and $25 be presented to winners of a drawing at the conclusion of the annual meeting. Pads of forms will be available at each technical exhibit booth, and all guest and member physicians will be eligible to participate.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

203rd annual meeting — Saturday-Wednesday, May 17-21, 1969

204th annual meeting — Saturday-Wednesday, May 16-20, 1970

205th annual meeting — Saturday-Wednesday, May 15-19, 1971

Recommendation

That the 206th annual meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Wednesday, May 13-17, 1972.

Approved (page 407)

Scientific Program*

James A. Rogers, M.D., Chairman, Paterson
(Reference Committee "H")



The Officers of the Scientific Sections, under the chairmanship of James A. Rogers, M.D., met jointly with the Committee on Annual Meeting to formulate the scientific programs for the 1968 convention.

The 1967 House of Delegates approved a resolution to create a Scientific Section on Plastic and Reconstructive Surgery. Section officers were elected, and this newly formed section will meet for the first time in 1968.

The following sections agreed to combine for presentation of six scientific sessions in 1968:

Allergy, Otolaryngology, Pediatrics (Monday)
Anesthesiology, Gastroenterology and Proctology, General Practice (Monday)
Cardiovascular Diseases, Medicine, co-sponsored by the Bergen County Heart Association (Tuesday)
Clinical Pathology, Metabolism (Monday)
Obstetrics and Gynecology, Urology (Monday)

The following sections are scheduled to meet singly:

Chest Diseases (Monday)
Dermatology, co-sponsored by the Industrial Medical Association of New Jersey (Tuesday)
Ophthalmology (Tuesday)
Orthopedic Surgery, in cooperation with the New Jersey Orthopedic Society (Monday)
Plastic and Reconstructive Surgery, co-sponsored by the New Jersey Society of Plastic and Reconstructive Surgeons (Tuesday)
Psychiatry and Neurology (Monday)
Rheumatism (Monday)

* Subcommittee of Annual Meeting Committee.

As the result of concurrent scheduling with the 3rd session of the 1967 House, attendance was very poor at the four special scientific sessions. The Board approved a recommendation that, for 1968, special scientific sessions be scheduled for Sunday, prior to the time of the meeting of the 2nd session of the House.

Two special scientific programs will be presented on Sunday — a Session on Religion and Medicine, sponsored by the Academy of Medicine of New Jersey; and a Session on Suicide, sponsored by the New Jersey State Department of Institutions and Agencies.

A total of 77 outstanding speakers will participate in the scientific program this year.

Approved (page 407)

Scientific Exhibits*

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")



This subcommittee, under the chairmanship of Milton Ackerman, M.D., took the following actions during the year:

1) Revised the scientific exhibit application form.

2) Distributed the revised application for the scientific exhibit to Medical Directors of all New Jersey, New York City, and Philadelphia hospitals; the Deans of New Jersey, New York City, and Philadelphia medical schools; all speakers on the scientific section programs; the New Jersey State Departments of Health and of Institutions and Agencies, and other allied organizations. The committee selected suitable exhibits in medical, surgical, and informational categories from the applications which were submitted.

3) The committee recommended that the cost of the electrical outlets in scientific and informational exhibit booths be assumed by the exhibitors.

4) Ciba Pharmaceutical Company was approached and agreed again to sponsor the Motion Picture Theatre. Six showings are scheduled — Sunday afternoon; Monday and Tuesday mornings and afternoons; and Wednesday morning.

5) The committee revised the MSNJ Award Plaques, establishing a more modern make-up in shape, size, and composition. It was agreed to provide the newly revised plaques for the first and second place awards in the scientific exhibit category. It was, additionally, the decision of the committee that in regard to awards, no more than five Honorable Mention Certificates should be presented.

6) The committee accepted the offer of the Mead Johnson Laboratories to provide an "Aesculapius Award" for the outstanding scientific exhibit at the 1968 annual meeting. It was the decision of the committee that judging for this award this year be limited to New Jersey exhibitors only. The committee suggested that a placard or poster be prepared as soon as possible after the judging and the awards are made — this poster to be placed in the registration area at a point where all in attendance would have knowledge of, and thus be able to view, the award exhibits.

Approved (page 407)

* Subcommittee of Annual Meeting Committee.

Credentials

Marcus H. Greifinger, M.D., Chairman, Newark
(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the committee's activities during the period April 1, 1967 to March 31, 1968.

	Associate	*Advancement to Active*	*Active*	*Total*
Received	212	191	59	462
Reviewed and found:				
Satisfactory	158	146	37	341
Unsatisfactory	0	0	0	0
Pending	54	45	22	121

The committee again expresses appreciation to the officers of component societies for their cooperation.

Approved (page 394)

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg
(Reference Committee "H")



No nominations were submitted this year to the committee. Consequently, no meetings were held during this administrative year.

Approved (page 407)

Finance And Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park
(Reference Committee "B")



A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal

The anticipated *Journal* deficit has decreased, for the fourth consecutive year. This can be attributed to several factors: (1) the continuance of the increased volume of advertising supplied both by SMJAB and our local agent; (2) the effects of a general advertising rate increase (July 1, 1966) and the new rate structure reflecting a 10 per cent increase for full-page advertisements and a 5 per cent increase for one-half page advertisements — effective July 1, 1968 — or upon expiration of current contracts; (3) and another satisfactory year with Periodical Press, which has been able to print the *Journal* more economically even though production cost have increased as of March, 1966 and again March, 1968.

The anticipated deficit for publication of *The Journal,* Journal Salaries including the editor and editorial secretary, Journal office expenses and travel, editor's insurance and salary taxes, editorial secretary's salary taxes, and other Journal expenses will be charged off to the unexpended balance in the budget accounts at the end of this fiscal year. A net surplus will still result in the 1967-68 total budget.

"Project Hope"

There were two fellowships granted to date on "Project Hope," and there is an additional one approved for the fiscal year now ending. For 1968, your Committee recommends, with concurrence of the Board of Trustees, that the House of Delegates authorize that this program be made a continuing project, that "Project Hope" be broadened to include voluntary service by non-military physicians in Vietnam; and that a maximum of six (6) fellowships be awarded annually on a "first come, first served basis," each carrying a stipend of $1,000 for a 60 day tour of duty aboard the S.S. Hope, her sister ship, or voluntary non-military service in Vietnam.

Special Per Capita Assessment

For 1968, the 1967 House of Delegates voted a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Academy of Medicine of New Jersey for postgraduate education programs of the Academy, to apply equally to all dues-paying members, with no reduction for associate members as in the past, and to be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

For 1969, your Committee recommends, with the concurrence of the Board of Trustees, that the 1968 House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Academy of Medicine of New Jersey for postgraduate education programs of the Academy; that it apply equally to all dues-paying members; and that the special per capita assessment be levied in addition to, and not as part of the budgetary assessment, with both beng paid at the same time. Your Committee further recommends, with the concurrence of the Board of Trustees, that the 1968 House of Delegates vote a budgetary appropriation to be included in the 1969-70 budget under D-4 — Medical Education Account.

1969 Assessment

The computation of cash surplus at the close of the current fiscal year is estimated at $223,060.67 — 48.8 per cent above the $150,000.00 sum which has been fixed as the desired surplus amount at the beginning of each new fiscal year.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1968 and 1969 per capita assessment to the 1968-69 fiscal year on the basis of $^7/_{12}$ of the 1968 assessment for the new fiscal year soon to commence (June 1, 1968) and $^5/_{12}$ of the 1969 assessment for the latter part of that fiscal year starting January 1, 1969.

The proposed budget for 1968-69 is $316,266.00. Seven-twelfths of the 1968 assessment applicable to this proposed budget is $149,684.01. This leaves $166,581.99 to be raised by $^5/_{12}$ of the 1969 assessment. On the basis of 6,384 paid members as of May 31, an assessment of $62.63 per capita will be necessary in 1969 to raise this amount — $^5/_{12}$ of $399,829.92 is $166,595.80. However, since the estimated cash surplus as of May 31 is $223,060.67 and the desired minimum cash surplus at the close of each fiscal year has been set at $150,000.00, the 1969 assessment can be set at $50.00 per capita by applying $33,595.80 from surplus toward the amount to be raised. $166,595.80 less $33,595.80 leaves a net amount of $133,000.00 to be raised. Six thousand three hundred eighty-four members paid at $50.00 is $319,200.00 $^5/_{12}$ of which is $133,000.00. The net cash surplus at May 31, 1968 will then be $189,464.87.

1968-69 Budget

The proposed budget for 1968-69 totals $316,266.00. It is the opnion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the Committee is listing explanatory footnotes on accounts showing a marked difference between current and proposed budgets.

Recommendations

1) That the budget for 1968-69 be adopted in the total sum of $316,266.00.

Approved (page 396)

2) That the 1969 dues assessment be adopted at $50.00 per capita, with no provision for a contribution to AMA-ERF.

Approved (page 396)

3a) That the House of Delegates authorize continuance of the provision for six (6) Fellowships, each carrying a stipend of $1,000, totalling $6,000.

Approved (page 396)

b) That "Project Hope" and "Vietnam" be established as a joint continuing program of The Medical Society of New Jersey and that fellowships be awarded on a "first come, first served basis."

Approved (page 396)

4) That the House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Academy of Medicine of New Jersey for postgraduate education programs of the Academy; and that it apply equally to all dues-paying members.

Approved (page 396)

5) That the special per capita assessment be set by the House in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Approved (page 396)

6) That the House of Delegates vote to include a budgetary appropriation in the 1969-70 budget under D-4 — Medical Education Account.

Approved (page 396)

ACCOUNT	CURRENT 1967–68 BUDGET	FOOT-NOTES	PROPOSED 1968–69 BUDGET
A – 1 — Executive Salaries	$ 62,365.00	(1)	$ 58,597.00
A – 2 — General Staff Salaries	79,874.55	(2)	94,351.00
A – 3 — General Executive Office Expense	14,400.00	(3)	15,000.00
A – 4 — Executive Travel	2,780.00	(4)	3,300.00
A – 5 — House Maintenance	15,670.00	(5)	17,800.00
A – 6 — Treasurer	4,770.00	(6)	5,700.00
A – 7 — Finance & Budget	75.00		75.00
A – 8 — Secretary	400.00	(7)	450.00
A – 9 — Salary Taxes	6,037.45	(8)	6,890.00
A – 10 — Insurance	6,425.00	(9)	8,450.00
A – 11 — House Reserve	5,300.00		5,300.00
C – 2 — Legislation	4,200.00		4,200.00
C – 3 — Public Health	2,400.00	(10)	2,500.00
C – 4 — Public Relations	6,300.00	(11)	6,750.00
C – 5 — Medical Services	700.00		700.00
C – 6 — Mental Health	1,000.00	(12)	1,350.00
D – 1 — President—Presidential Officers	9,590.00	(4)	10,590.00
D – 2 — AMA Delegates	8,580.00	(4)	11,060.00
D – 3 — Woman's Auxiliary	3,025.00	(13)	5,925.00
D – 4 — Medical Education	100.00	(12)	150.00
D – 5 — Conference Groups	500.00		500.00
D – 6 — Membership Directory	9,450.00	(14)	14,753.00
D – 7 — Emergency Medical Care	325.00		325.00
D – 8 — Credentials, Membership Directory	250.00		250.00
D – 9 — Archives & History	100.00		100.00
D – 10 — "Project Hope"	6,000.00		6,000.00
D – 11 — Medical Defense & Insurance	300.00	(15)	500.00
E – 1 — Board of Trustees	5,500.00	(15)	5,900.00
E – 2 — Contingent	10,000.00		10,000.00
E – 3 — Judicial Council	500.00		500.00
E – 4 — Legal	8,300.00	(16)	5,300.00
E – 6 — Medical Student Loan Fund	13,000.00		13,000.00
TOTAL	$288,217.00		$316,266.00

FOOTNOTES FOR BUDGET

(1)—Decrease due to changes in executive personnel.

(2)—Increase due to merited increment, and an additional staff member on the general staff.

(3)—Increase due to higher office service expenses.

(4)—Increase due to AMA Annual Meeting in San Francisco, California, and Clinical Meeting in Miami, Florida.

(5)—Increase due to higher house maintenance expenses, which include executive offices property taxes.

(6)—Increase due to anticipated cost expected for conducting the annual audit and a study of tax obligations of this non-profit organization.

(7)—Increase due to higher cost in travel and expenses.

(8)—Increase due to higher salary taxes and one additional employee on the general staff.

(9)—Increase due to the inclusion of an added fringe benefit for MSNJ permanent employees — Group Life and Major Medical Insurance.

(10)—Increase due to higher anticipated cost for the 1968 Eye Health Screening Program.

(11)—Increase due to higher anticipated cost to conduct certain programs under Public Relations.

(12)—Increase due to higher anticipated travel expenses.

(13)—Increase due to AMA Annual Woman's Auxiliary meetng in San Francisco, California.

(14)—Increase due to the new 1968-69 *Membership Directory*, to be ready for distribution in the fall of 1968.

(15)—Increase due to higher anticipated expenses.

(16)—Decrease due to a proposed change of legal counsel.

Approved (page 396)

Medical Defense and Insurance

Fred A. Mettler, M.D., Chairman, Blairstown
(Reference Committee "D")



Accident and Health Insurance

The Society's accident and health insurance program which began in 1930 has just completed another successful year. During the past year, the Society added the Long-Term Professional Income Protection Plan of the Nationwide Mutual Insurance Company, which provides up to an additional $1,000 monthly benefit and pays accident benefits for life and sickness benefits to age 65 and beyond. In the short time this program has been in effect, 323 members have added it to their disability insurance program.

With this new addition, our members have great choice in building their disability program, using the Society's endorsed plans. In addition, there are the National Casualty Company and Nationwide Mutual Insurance Company basic programs providing accident benefits up to five years and sickness benefits for two years, with a total maximum monthly benefit of $1,200, $600 in each company. To this may be added the Extended Professional Disability Policy of these companies, extending sickness benefits to seven years and accident benefits to lifetime. A total of 3,761 members hold the National Casualty Company basic policy, and 2,895 hold the Nationwide Mutual Insurance Company basic policy.

The basic programs have benefits beginning on the first day of an accident disability and the eighth day of a sickness disability. In the Long-Term Professional Income Protection Plan, benefits may begin on either the first day of an accident and the eighth day of a sickness, or the 15th, 31st, 61st, or 91st day of a disability, with appropriate reductions in premium for the longer waiting-period plans. Members may therefore use Society-endorsed plans to fit their personal needs in disability income programming. During 1967, $615,817.82 was paid our members under these plans, providing benefits to them to help replace income lost through accident or sickness.

Members who apply for the basic and extended policies within their new-member periods are issued coverage, within certain limits, without regard to medical history.

Major Expense Plan

Our Major Expense Plan provides up to $15,000 of benefit paying 80 per cent of covered expenses of a $500 deductible. Members totaling 2,714 plus dependents are participating in this program at the present time. During 1967, $178,498.68 was paid to our members under this plan.

Life Insurance — Nationwide Life Insurance Company

Our life insurance program provides a five-year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance. The program provides up to $100,000 of coverage in units of $10,000 with waiver of premium and double indemnity for accidental death included without extra premium charge. During 1967, the dividend scale was increased for the third time since the program began in 1959.

In 1967, 14 of our members who participated in this program died. Of interest is the fact that only two of the members held more than the basic $10,000 life insurance amount. One of our deceased members held $50,000 of life insurance, and another held $20,000 of life insurance under the program. Ten of the

deceased policyholders obtained their insurance because of the qualification of the group in the initial enrollment and would not have been eligible for insurance under normal underwriting regulations. It is the impression of your Committee that the benefits available under this feature of the program are being underutilized. Through the very large volume of insurance and strong participation of our members in this program, we are able to have life insurance at a very low cost and yet provide this important coverage for such members. Since the inception of the life insurance program in 1959 there have been 138 death claims with a total of $1,343,000 paid out in benefits. At the present time, 1,755 of our members participate in this program, with $25,670,000 of insurance currently in force.

Six Point High-Limit Accident Insurance Plan

Our six Point High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company provides up to $200,000 for Accident death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone. Special spouse coverage is available under this policy at very low cost. Six hundred ninety-four of our members participate in this program.

Recommendation

That the E. & W. Blanksteen Agency be continued as the official broker for our Accident and Health, Life, High-Limit Accident, and Major Expense Programs.

Approved (page 398)

Group Automobile Insurance Coverage

Resolution #5 of the 1967 House of Delegates directed the Committee on Medical Defense and Insurance to investigate the possibility of providing a group automobile coverage for the members of MSNJ. The Committee conducted an extensive survey of the automobile insurance field. All of the companies contacted replied that they were not interested in group automobile insurance coverage. In addition, Aetna Life & Casualty was told by the New Jersey State Department of Banking and Insurance that such a plan is considered "ficticious grouping" which is in violation of departmental regulations.

Professional Liability Coverage

American Mutual announced in January that it would no longer provide coverage for new members as of January 15 and that it would retire from the entire risk by November 1, 1968. Consequently, the Committee has had to survey the professional liability insurance field in an effort to secure coverage for the members of MSNJ.

Several offers are under consideration at the present time. The decision of the Committee will be transmitted to the House of Delegates in its supplemental report.

Approved (page 398)

Supplemental Report

Professional Liability Insurance

At its first meeting for the year 1967-1968 (July 9, 1967), your Committee resolved to see what could be done about your mandate to take whatever action was necessary toward counteracting, insofar as might be possible, the continuing increase in our rates for professional liability insurance. As a first step it asked our then carrier, American Mutual Liability Insurance Company, to make a statement as to whether the rates then current would be in force for another year.

By the next meeting of the Committee (October 8, 1967), the Company had still not replied to this inquiry. Subsequently, the Company asked for an opportunity for two of its vice-presidents to meet with the Committee for a discussion. This meeting was arranged for November 12, 1967. In view of the many questions and complaints from individual members about the last rate increase, representatives from each of the component societies were invited. At the meeting, the two

vice-presidents presented statistics which were, from the point of view of the county representatives, principally self-declaratory and largely non-responsive. Essential issues were avoided in a didactic presentation, and the discussion was kept on the plane of generalities. For example, the issue of the degree of loading for delayed discovery was never mentioned, and no answer was forthcoming as to what rates would be requested for 1968-1969.

Immediately following this joint meeting, the Committee met formally to determine whether the position taken by the American Mutual could be considered representative of the industry as a whole. This investigation was specifically stated to be without prejudice with regard to American Mutual and to determine if that company was, indeed, giving our members the best available program at a charge which could be considered properly competitive. A special study subcommittee, with Dr. Greifinger as chairman and Dr. Hillman as a member, was appointed to contact other companies and to determine what charges other dependable companies would request to write our program with the same benefits.

The next meeting of the Committee on Medical Defense and Insurance was scheduled for January 14, 1968 when a report of the subcommittee was to be presented. Immediately prior to this, American Mutual advised your chairman that it was unhappy because of the critical attitude displayed at the November meeting and because it had learned that other companies were being approached. Through its vice-president, Mr. Vanderwarker, the Company stated that it did not relish having its rates questioned or that it be asked to take its place in the competitive market. Mr. Vanderwarker declared that the Company wished to terminate the agreement but said, if it continued, an increase in rates between at least 30 per cent and 40 per cent would be effective in 1968. A formal letter from the Company was received on January 11, 1968, advising that no new policies would be accepted after January 15, and further advising that if the Company were to continue, a substantial rate increase would be required. The exact extent of this increase was still not specified. This precipitate action made it necessary for your Committee to make emergency arrangements for insurance for those member-physicians who could not get coverage through local agents. Among the companies contacted by Dr. Greifinger was Employers Insurance of Wausau, the Company writing the insurance program for the New York State Medical Society. This organization now offered a program which included not only all the past accomplishments and improvements of our arrangements but also other important improvements (such as regular reporting of claims and settlements in dollar amounts) which had not, in the past, been possible to obtain through American Mutual.

Some time prior to January, Mr. Joseph Britton, the New Jersey Manager of the professional liability program for American Mutual, had retired from that organization. With his retirement another problem was added. The Company's higher management appeared to be unfamiliar with important operational details of our program and apparently also did not understand the way in which a state medical society operates. It must be recalled that our program had been largely developed by our beloved late chairman, Dr. Daniel Featherston, in association with Mr. Britton. Mr. Britton offered to help us and to give us the benefit of his knowledge and advice during this trying period. The Society owes Mr. Britton a debt of gratitude for this service, which he performed without any compensation (even for the expenses necessarily incurred in this connection).

On February 28, 1968, Mr. Vanderwarker and Mr. Hazam met with representatives of the Board of Trustees, and on March 13 a letter was received which finally stated what the rate increase would be — the increase American Mutual would have to have to continue the business. This was answered by Dr. Albright for the Board of Trustees, stating, in part:

On the basis of your two letters referred to, the Board weighed the following conditions for American Mutual's reinstatement of coverage:

1. An increase of 52.3 per cent in premiums for all classes of doctors covered.

2. A formal resolution of acceptance of such rate increase by MSNJ, to be used in support of the Company's planned filling with the Commissioner of Banking and Insurance, in order to make the Society a joint petitioner for the Commissioner's granting of the full 52.3 per cent increase in all premiums.

3. No resumption of new business by American Mutual until the commissioner has granted the 52.3 per cent increase.

The Board very carefully weighed the proposal and all its implications. By unanimous action the Board voted to reject the proposal, and directed that American Mutual be so informed without delay.

On the basis of these negotiations, the Committee on Medical Defense and Insurance (at its March 24 meeting) voted American Mutual unacceptable for further negotiations. Among the other proposals which were brought before the Committee on Medical Defense and Insurance at its March 24 meeting for possible recommendation to the House of Delegates at the present meeting were several interesting propositions which were not considered as fully or well-developed as that of Employers Insurance of Wausau.

The study committee had also given its attention to the possibility of self-insurance, as was recently suggested by the presidents of the county medical societies. This proposition, however, requires much more study and development than could be given to it at the present time, and a subcommittee has been appointed to pursue the subject for future reference. It was then resolved to recommend the adoption of the proposal by Employers Insurance of Wausau, with Mr. Britton appointed as the Society's broker to administer this program for us along existing lines. The new Company will, however, work on an 80 per cent loss ratio instead of the figure of 75 per cent used by American Mutual. This should tend to act as a brake to slow the increasing rate trend which we cannot, however, expect to reverse at this moment.

There are many reasons for the increasing rate trend. It is the business of your Committee to ensure that such increases remain within justifiable limits and that the membership as a whole gets proper value for its expenditures. In such determinations the interests of the Society as a whole must take precedence over the limited interest of one or another specialty group or geographic segment. Experience has shown that where special interest leads a group to pursue a course apart from that of the general membership, ultimate developments are to the disadvantage of the special-interest group. As Dr. David Kershner in his report to the 1968 House of Delegates of the Medical Society of the State of New York declared:

The simplest answer to why closing costs have increased is inflation. A survey of suits closed during 1966 shows that the policy year in which the alleged malpractice occurred preceded the year of closing by an average of more than five years. This means that premium rates, if they are to be adequate, must take into account future inflation, which it is generally conceded will amount to from 3 to 5 per cent a year, provided it is kept within "acceptable" limits.

It is to be hoped that the relatively small (in comparison with the request of American Mutual) increases in premiums which we anticipate with our new carrier will purchase us substantial benefits. In addition to the personal service of Mr. Britton, some of the improvements offered by the new Company, subject to approval by the New Jersey Department of Banking and Insurance are:

1) No surcharge will be made for physicians employing nurses or technicians other than x-ray therapists and electrologists.

2) No surcharge will be made for an employed physician if he is insured under the program.

3) A new class will be established for physicians essentially retired or for those in corporate administrative employment and not in active practice. The rate for this group will be 60 per cent of the Class 1 rate which, at present, is the lowest.

4) In order to meet the repeated objection from the membership that the man who maintains a careful practice is carrying the burden of his careless colleagues, the Society,

through this Committee, will actively participate in the underwriting of physicians whose record of claims makes their insurability questionable, with consideration being given to the possibility of a surcharge in individual cases. By this means every physician member in good standing should remain insurable even though subject to such surcharge.

5) To further implement the loss prevention facet of our program, bulletins will be furnished to our insured members giving histories and case studies of malpractice claims.

It was felt by your Committee that your interests cannot be properly served by dealing directly with employees of insurance companies. Even if well-trained, such employees are generally not allowed sufficient freedom to make decisions of a critical nature at times when such decisions need to be made and executive personnel is often inaccessible. Our recent direct experience with American Mutual as compared with that with the E. and W. Blanksteen Agency has convinced us that there are important benefits to be derived from the services of our personal indemnity representative who is both knowledgeable and zealous, who is located within easy reach of his clients, and who is able to remain temperate in the face of the inevitable petty irritations of practical living.

The vitality of an insurance program, like that of the human body, is derived from a turnover of energy. It depends on service. Someone has to do the work, and such work cannot be done from an administrative armchair. If this were the case, clients would need no direct writer to act as middleman but would go directly to the professionals in the industry — the reinsurance group. It is a mistake to suppose that the brokerage system is necessarily more expensive than direct contracting. If work is to be done, it matters little whether it is done in the company or outside it. What is important are the reality of the service, its quality, and who is being served — whether it is the company alone or a mutually advantageous interest. Mr. Britton's compensation, like that of the Blanksteen Agency, will be on a fee basis with the insurance company, but his performance and tenure will reside under the annual scrutiny of the Committee and at the pleasure of the House of Delegates. He will report to, and work through, this Committee, as is the case with our other insurance programs, and the direct writer, Employers Insurance Company, agrees to provide us, through him, with a detailed accounting of all claims and charges, by individual case, upon November 1 of each year.

Recommendations

(1) That the Employers Insurance of Wausau be engaged as the official professional liability insurance carrier for The Medical Society of New Jersey for 1968-69.

Approved (page 398)

(2) That Joseph A. Britton be designated as MSNJ's official broker for its professional liability insurance coverage.

Approved (page 398)

Approved as a whole (page 398)

Drugs Against Cancer

The Public Health Service has available now a 17-page report on cancer chemotherapy. You may get a single copy free by asking for PHS Publication 1652, and directing your request to National Cancer Institute, Bethesda, Maryland 20014. For extra copies, the charge is 15 cents each, and these are sold by the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402.

Medical Education

Sherman Garrison, M.D., Chairman, Bridgeton
(Reference Committee "D")



The committee discussed a wide variety of subjects during several meetings this past year.

Questionnaire

The committee distributed a questionnaire to determine why members do — or do not — attend postgraduate educational meetings. Of the 2,368 answering the questionnaire, the majority indicated that hospital staff meetings were for them the greatest source of continuing medical education. Seventy-nine reported that they attended no meetings at all the past year. Additional results indicated that greater contributions could be made by component societies (14 per cent), use of tapes (10 per cent), contact with colleagues (10 per cent), use of motion pictures (12 per cent). The remaining 63 per cent had no request for further contributions from any source. In response to "when meetings should be scheduled," the replies were: weekdays (35 per cent), weekends (25 per cent), evening sessions (25 per cent). Seven and a half per cent felt they were not receiving adequate information at the present time. Failure to attend meetings was generally attributed to the type of program (15 per cent) and to the speaker (4 per cent).

Medical Schools

A conference was held with representatives of the New Jersey Chapter of the Academy of General Practice to discuss proposed legislation aimed toward increasing the number of practicing physicians. (New Jersey ranks sixth nationally in number of residents who enter medical schools.) When the proposed legislation is available, a copy will be submitted to the Society's Council on Legislation for evaluation.

Letters have been sent to the deans of both medical schools in New Jersey, suggesting an annual conference to review items of mutual interest and concern — particularly long-range planning in medical education.

Medical Education

The committee has concluded that continuing medical education at postgraduate level is basically oriented as a hospital staff function. The committee feels, however, that a gap exists in making yearly review information easily accessible to the average physician in the following areas: (1) therapeutic measures in medicine, surgery, radiology, pediatrics; (2) new diagnostic techniques — including x-ray, laboratory, and clinical; (3) new disease syndromes and those increasing in prominence; (4) new drugs — and particularly drug reactions; (5) new medical-legal decisions affecting medical practice or specialties and significant trends from experiences in New Jersey; (6) current patterns and concerns reported from the State Department of Health.

The committee commends the Academy of Medicine for an excellent job in providing throughout the state symposium programs covering many fields. The program committee of the Academy is prepared to assist any group in the organization and/or formulation of programs in medical education.

Intern-Resident Problems

The committee has developed a questionnaire for distribution to hospital directors of medical education, to elicit information regarding affiliations, plans, and current problems. Dr. William Snagg of the committee is preparing a paper on the intern-resident problems.

Teaching Responsibilities

It is the opinion of the committee that in

all hospitals physicians, in order to maintain hospital privileges, should be required to attend some form of teaching rounds and to participate in actual case discussions in accordance with rules established by the medical staff.

Continuing Education

At the suggestion of the Board of Trustees, the committee is preparing for submission to *The Journal* an article on current activities, techniques, and studies in the field of graduate medical education. The committee is of the opinion that graduate education is becoming increasingly significant, and in view of the rapid changes occurring in this field makes the following recommendation to the House of Delegates:

Recommendation

That a representative of this committee be sent to the annual meeting of the American Medical Association's Council on Medical Education, as official representative of MSNJ.

Approved (page 398)

Approved as a whole (page 398)

Medical Student Loan Fund

Luke A. Mulligan, M.D., Chairman, Leonia
(Reference Committee "B")



In its eleven years of operation the Medical Student Loan Fund has granted loans totaling $207,244.35, including $444.35 as insurance payments, making the net loans granted $206,-800.

To date the Fund has issued 210 loans to 127 New Jersey medical students. Nineteen loans have been repaid in full. Seventeen borrowers are presently making repayments on a quarterly annual basis, and eight borrowers are presently making interest payments only.

The result of a time-cost study of Fund operations approved by the Board shows an average administrative cost to MSNJ of approximately 5 per cent for each $1,000 loan granted. This includes supplies, postage, and initial record-keeping. However, to conduct the overall business affairs of the Fund during the 1967-68 fiscal year, the cost averaged 10 per cent of an assigned employee's annual salary. Your committee feels that the study thus far is not conclusive. More time was devoted to improving the established procedure in processing a loan and setting up a status control on each outstanding loan. Thus, these data are submitted as an interim report.

Therefore, the committee has unanimously concluded that the study should be continued for an additional year, so as to present more realistic data upon which decision will be made for charging administrative costs directly to the Fund.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Present Location of Recipients of Loans

105 graduates with an M.D. degree are located as follows:

- 20 Interns — 14 in New Jersey and 6 out-of-state
- 40 Residents — 19 in New Jersey and 21 out-of-state
- 31 Armed Services—24 Army of the United States and 7 United States Navy
- 14 Private Practice — 5 New Jersey, 3 Pennsylvania, 3 California (includes Austin), 1 Connecticut, 1 Colorado, and 1 Massachusetts

8 Students presently in medical school (5 Seniors, 3 Sophomores)

113

14 Loans paid in full

127 Total

Contributions

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; County Woman's Auxiliaries; Bergen, Burlington, Cape May, Essex, Gloucester, Mercer, Middlesex, and Passaic County Medical Societies.

Mrs. John Abajian, Jr.; Martha B. Abel; Mr. and Mrs. C. Shelly Acuff; Dr. and Mrs. Anthony Ambrose; Mrs. Jacob J. Belfer; Dr. and Mrs. Victor Boogdanian; Mrs. Joseph Borrus; Dr. and Mrs. Ralph K. Bush; Dr. and Mrs. A. Guy Campo; Mrs. Frank Campo; Mrs. Anna Cieslikowski; Mrs. Don A. Epler; Dr. and Mrs. Philip Fiscella; Mrs. Lewis C. Fritts; Dr. and Mrs. Floyd D. Gindhart; Katherine N. Haggerty; Mrs. John Helff; Mrs. Edward Jasionowski; Dr. and Mrs. Raymond M. Kostrzewa; Mrs. William Kuhn; Mrs. Philip Kunderman; Dr. and Mrs. John F. Kustrup; Dr. and Mrs. Samuel J. Lloyd; Dr. and Mrs. Nicholas E. Marchione; Middlesex General Hospital Medical Staff; Mrs. Bernard Miller; Dr. and Mrs. Luke A. Mulligan; Dr. and Mrs. Paul H. Pettit; Mrs. Gabe Pickar; Dr. and Mrs. Paul Rauschenbach; Mrs. James Rogers; Mrs. Norman Rosenberg; Dr. and Mrs. George O. Rowohlt; Dr. and Mrs. Robert Salasin; Mrs. John S. VanMater; Mrs. H. Roy Van Ness; Mrs. Robert Zullo.

In Memory Of

Nicholas F. Alfano, M.D.; Nelson S. Archbold; Mrs. Isiah Barkley; F. Clyde Bowers, M.D.; Grace Buttolph; Mrs. Joseph A. Clarken; Jemima Colwell; Mr. C. S. Currin; Mrs. Lawrence Dramer; Mrs. Joseph I. Echikson; Rose Ferren; Mrs. Henry Freund, Jr.; Max Friedman, M.D.; Charles Gugels; Marguerite Hamilton; Doris Stern's sister; Elizabeth L. Hipple; Bernard A. Hirchfield, M.D.; Ella Cox Hughes; John F. Johnson, M.D.; Mrs. John Kratzer; George Lazzer, Sr.; Mrs. Jennie Ledden; Mrs. Lewis Ledden; Mrs. John Lenander; Milton Makowsky; Hugh Miller; John Morvay; Charles A. Munro, M.D.; Mrs. Robert W. Powers; Joseph T. Salvatore, M.D.; Benedict Scassera, M.D.; E. Lester Small, M.D.; Warren J. Smith; Mrs. Joseph Sorett; Mrs. B. Tedesco; Andrew Tilbian; Jerome Ulan, M.D.

In Honor Of

Arthur E. Sherman, M.D.; Mrs. Jesse T. Glazier; Mrs. John F. Kustrup; Mrs. David Zuckerman.

Bicentennial Commemorative Contributions

Although the 1967 report presented a complete list of such Bicentennial Commemorative Contributions as had then been made, this year there is one more to be added: The Woman's Auxiliary to The Medical Society of New Jersey.

Your committee is happy to report that there are now installed on an appropriate wall within the executive offices in Trenton two plaques designating (1) the names of donors of $500 or more; and (2) the names of those giving $100 or more (but less than $500).

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted 1957-1967*	*1967-1968 March 31, 1968*
Atlantic	Hahnemann	3	$ 2,000.00	$1,000.00
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	N. J. Medical	7	11,000.00	
	N. Y. Medical	1	1,000.00	
	St. Louis	1	1,500.00	

County of Residence	*Medical School*	*Students*	*Loans Granted* 1957-1967	1967-1968 March 31, 1968
Burlington	Duke	1	4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	1	2,000.00	
Camden	Jefferson	1	2,000.00	
	Michigan	1	2,000.00	
	N. J. Medical	2	2,700.00	
	Temple	3	3,500.00	
	Hahnemann	2	2,000.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Duke	1	2,000.00	
	Hahnemann	2	5,000.00	
	Howard	1	300.00	
	N. J. Medical	9	15,500.00	$1,000.00
	N. Y. Medical	2	2,000.00	
	St. Louis	1	500.00	
	Temple	1	1,000.00	
	Georgetown	1	1,000.00	
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	U. of Virginia	1	1,000.00	
Hudson	Georgetown	1	1,000.00	
	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. J. Medical	18	26,150.00	
	N. Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N. J. Medical	3	8,000.00	
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00	
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	4,000.00	
Monmouth	Columbia	1	2,000.00	
	Georgetown	1	1,000.00	
	Jefferson	1	3,000.00	
	Marquette	1	2,000.00	
	N. J. Medical	3	6,000.00	$1,000.00
	N. Y. Medical	1	4,000.00	
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N. J. Medical	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N. Y. Medical	1	1,000.00	
Somerset	Georgetown	1	1,000.00	
	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	N. J. Medical	11	17,800.00	
15 Counties	28 Medical Schools	127	$203,800.00	$ 3,000.00

Total loans granted 3/31/68 .... $206,800.00

Recommendations

1. That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving the Budget appropriation ($13,000) in lieu of a special per capita assessment for 1968-69 in support of the Medical Student Loan Fund.

Approved (page 396)

2. That the MSNJ membership be urged to continue to send contributions to the Fund.

Approved (page 396)

3. That the Woman's Auxiliary to The Medical Society of New Jersey again be requested to keep the Fund one of its primary objectives during 1968-69.

Approved (page 396)

4. That the time-cost study of Fund operations approved by the Board of Trustees continue for an additional year, so as to present more realistic data upon which decision will be made for charging administrative costs directly to the Fund.

Approved (page 396)

Approved with the following recommendation:

That the present maximum allowance of $1,000 per year per student be increased to a more realistic figure of $1,500. (page 396)

Seven Per Cent Choose Medicine

The practice of medicine continues to be a preferred career choice among some of the nation's scholastic elite — semi-finalists in the National Merit Scholarship Program — although the number planning to study medicine has declined from a year ago.

This has been revealed by an AMA study of a listing of the 14,000 students honored as semi-finalists in the 13th Annual Merit program for 1968. All are in the 99th percentile of the nation's graduating seniors. Of the 10,780 career-decided students, *seven per cent* (767) indicated that they seek to become doctors of medicine. This represents a drop from the 950 figure of a year ago when eight per cent indicated medicine at their career choice. An offsetting factor, however, was that last year was a "bumper year" in which 159 *more* semi-finalists listed medicine as their career choice than did so in the 1965 program.

For the third consecutive year one of every three semi-finalists indicated a decision to enter medicine or an allied field. Twenty-seven per cent of all career-decided candidates plan to become either physicians, physicists (643), scientists-unspecified (543), chemists (352), biologic scientists (341) or biochemists (212).

If the 3,221 career- undecided or unreported semi-finalists in the 1967-68 program were to make career choices at the same ratio as the 10,779 who have reached their decisions, it would indicate that 996 plan to study medicine. The comparable figure for the 1966-67 candidates was 1,133.

Numbers choosing other professions included in the compilations were physical scientist, 97; social worker, 91; nursing, 84; medical technologist, 62; veterinarian, 56; dentist, 30; pharmacist, 29; biophysicist, 20; and physical therapist, 18.

Publication

George B. Sharbaugh, M.D., Chairman, Trenton
(Reference Committee "B")



It is said that there is no monument to Christopher Wren in London, because all you have to do is to look at St. Paul's and there it is! So, with *The Journal*. We really don't need an annual report. Look through its pages and there it is!

As any one can see from these figures, our *Journal* is getting bigger — and, we think, viewed objectively, it is getting even better. See for yourself:

	1964	*1965*	*1966*	*1967*
Total of Text Material	530	592	578	704
Advertising	482	485	660	788
Grand Total of Pages	1012	1077	1238	1492
Ratio: Advertising/Text	48%	45%	53%	53%

What's your criterion? Sheer size? Well, in 1964, we had a bare 1,000 pages — last year we had 1,492, practically a 50 per cent increase. While our advertising escalated, the text material did so too — 530 pages to 704 pages in the short span of four years. As for income, our gross, mostly from advertising, for the nine months period from June 1, 1967 to March 1, 1968 was $51,462 — the total income for this period last year was $45,952. The detailed financial statement for *The Journal* appears in the report of the Treasurer.

Mr. Cookson has proved himself a dynamic and effective advertising manager, who never forgets the ethical side of his work. Only advertising acceptable to the committee is approved.

The State Department of Health asked us to carry a "communicable diseases" section and we have done so. It has, somewhat unexpectedly, proved to be one of the best read sections in *The Journal*. We have consolidated several previously scattered departments into a unified "Doctors' Notebook" section. The blue paper in the April issue nicely dressed up the Annual Meeting Program section of our periodical.

We are increasing our advertising rates, as of July 1, 1968, but *The Journal* still remains one of the best bargains in the advertising field. The rise of printing costs has forced us, somewhat reluctantly, to up our reprint charges to authors. We have negotiated a new contract with Periodical Press Corporation of Philadelphia. In return for getting a three year contract, we assented to a 5 per cent increase in printing rates which, in these days of skyrocketing costs, is quite acceptable.

The future of drug advertising is somewhat uncertain, because no one can predict what the Food and Drug Administration will do with respect to additional restrictions on the advertising copy submitted by pharmaceutical manufacturers.

Mrs. Marjorie Treptow continues as our editorial secretary, reader of the proofs, hostess to phone calls from authors, members, and readers, general factotum in the editorial department, typist, stenographer, and Girl Friday in that office. She is being advanced to the title of Assistant Editor — Archivist of the Society.

Dr. Davidson is one of the senior state journal editors in the USA. He is frequently invited to speak at editorial conferences throughout the country, and his *Guide to Medical Writing* (Ronald Press, New York City) is a standard text for authors and editors.

We have a small office for our *Journal* — Mrs. Treptow is the only full-time worker there — and we do a prodigious job. We, of the Publication Committee, are proud of *The Journal* and hope you are, too.

Approved with commendation for the excellent progress being made. (page 396)

Revision of Constitution and Bylaws

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee on Constitution and Bylaws)



Again this year, the committee had several proposals before it and dealt with each one separately and in detail—to carry out its function (Chapter IX, Bylaws, Section 17, b):

The committee shall be responsible for perparing and/or evaluating proposed revisions to the Constitution and/or Bylaws, and for properly submitting them to the House of Delegates.

The committee also reports in detail on the referral from the 1967 House of Delegates. The committee urges that all members of the House study this report in advance of the convention and carefully evaluate the proposals made. Members of the House should also remember that last year's amendment to the Constitution (Article VI — Board of Trustes) is up this year for its "second and final year" vote.

Referral from 1967 House of Delegates

The committee considered the following relevant excerpt from the report of the 1967 Reference Committee on Constitution and Bylaws:

It was the opinion of the reference committee that some procedure might be evolved that would give more equitable representation to populous counties on the Nominating Committee without "weighted voting" by one person.

It is for this reason that your reference committee *recommends* that the entire matter of reapportionment of representation on the Nominating Committee be returned to — and studied in depth by — the Committee on Revision of Constitution and Bylaws, for subsequent report to the House.

The Committee reviewed its previous deliberations (in 1966 and 1967) when the proposal of reapportionment of the Nominating Committee was studied in depth. The 1966 and 1967 proposed amendments involved "weighted voting," which the House of Delegates — at least by implication — has consistently opposed. In discussing the 1968 proposal of Essex County, the Committee noted that — even though each member of the Nominating Committee "shall cast an individual vote" — the amendment calls for a controlling nominating delegate who will be "spokesman for his delegation in the course of nominating and seconding of candidates." This provision, the Committee believes still involves the principle of "weighted voting."

It was the opinion of Legal Counsel — concurred in by the Committee — that proportional representation is important only where final actions are taken. The House of Delegates takes final action. The Board of Trustees, acting in behalf of the House between annual meetings, takes final action. Both groups are proportionally represented. The Nominating Committee, however, is merely a mechanism which moves toward action which is finalized by the House. Proportional voting does not seem significant or important here since the right to nominate from the floor is also held by the House.

In evaluating the Nominating Committee as presently constituted, the Committee was unanimous in its conclusion that:

1. Every county has equal opportunity to submit names of candidates for office.

2. The right to nominate from the floor gives adequate protection and representation to the more populous counties who have qualified candidates for offices they want recognized.

3. The Committee functions smoothly and efficiently, without reference to pressure from geographical influence.

4. The entire concept of a Nominating Committee is to select the most qualified candidates to serve on a statewide basis, exclusive of size of county or geographical location.

5. Qualitative selection is made by the Nominating Committee. Quantitative election is made by the House.

In view of all the foregoing, after extended deliberation and discussion, the committee was unanimous in its decision that a change in reapportionment of the Nominating Committee is not desirable — and so reports to the 1968 House of Delegates.

The committee unanimously *recommends* to the House that no change be made in the Nominating Committee.

Approved (page 409)

Proposed Amendments to Constitution and Bylaws

Article XII and Chapter XII of the MSNJ Bylaws require that all proposed amendments be transmitted by the Secretary to the Committee on Revision of Constitution and Bylaws not later than February 15; that they be studied by the committee; and that the committee report on them at the first session of the House of Delegates. In accordance with these provisions, the committee received from the Secretary the following proposals for consideration by the 1968 House of Delegates and took the actions indicated.

Reapportionment of Board Representation

The Bergen County Medical Society submitted a proposal to provide more equitable representation of populous districts on the Board of Trustees (Constitution — Article VI . . . Board of Trustees).

Preparation: The committee unanimously agreed that the format submitted (Exhibit #1) was proper for transmittal to the 1968 House of Delegates.

Evaluation: The committee *recommends* to the 1968 House that the appropriate reference committee make determination concerning the priority of this proposal. In view of the action of the 1967 House in approving the Board's amendment to the same section of the Constitution, it would appear in order for the reference committee to recommend that the amendment of last year be considered first, in accordance with the "second year procedure" outlined in the Constitution. It would then be proper for the Bergen County proposal to come before the House — upon recommendation of the reference committee — for consideration in accordance with the "first year procedure," which requires only a majority vote.

Exhibit #1 Disapproved (page 408)

Reapportionment of Nominating Committee

The Essex County Medical Society submitted a proposal again this year to reapportion voting strength in the Nominating Committee in favor of more populous counties (Bylaws — Chapter V . . . Procedure of Election).

Preparation: The committee unanimously agreed that the format as submitted (Exhibit #2) was proper for transmittal to the 1968 House of Delegates.

Evaluation: The committee discussed in detail reapportionment of the Nominating Committee as reflected on earlier in this report. In view of its action in this area the committee unanimously *recommends* to the House that the proposed amendment from the Essex County Medical Society to reapportion voting strength in favor of more populous counties be not approved.

Exhibit #2 Not approved (page 409)

Membership Lists

The Essex County Medical Society also submitted a proposal to make the relevant section of the Bylaws compatible with the proposed amendment to Chapter V (Bylaws — Chapter I . . . Membership, Section 2 (d) List of Members).

Preparation: The committee unanimously agreed that the format as submitted (Exhibit #3) was proper for transmittal to the 1968 House of Delegates. The committee also agreed that if the Essex County amendment concerning the Nominating Committee is adopted this amendment is necessary.

Evaluation: Since this proposed amendment is inter-related with Exhibit #2 (Reapportionment of Nominating Committee), the committee likewise *recommends* that this amendment be not adopted.

Exhibit #3 Not approved (page 409)

Board of Medical Examiners

The Board of Trustees submitted a proposal to make the Society's Bylaws consistent with state law concerning submissions of nominees for membership on the Board of Medical Examiners of New Jersey (Bylaws — Chapter VI . . . Rights and Duties of Officers, Section 5 (f) Board of Trustees).

Preparation: The committee unanimously agreed that the format as submitted (Exhibit #4) was proper for transmittal to the 1968 House of Delegates.

Evaluation: The Committee *concurrs* in the recommendation of the Board of Trustees that MSNJ Bylaws should be consistent with current New Jersey law in this area of concern.

Exhibit #4 Approved (page 409)

Exhibit #1

Constitution

Article VI — Board of Trustees

Current	*Proposed*
The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary and Treasurer (by virtue of their offices) and eleven (11) members — at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary and Treasurer (by virtue of their offices) and *representative Trustees from each judicial district as follows: two (2) Trustees for the first five hundred (500) Active Members or fraction thereof and one (1) additional Trustee for each additional five hundred (500) Active Members or fraction thereof,* who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.
Any member may be elected a Trustee for a maximum of three (3) full terms.	Same
	A survey of the membership of The Medical Society of New Jersey by judicial districts shall be made every five (5) years as of January first of the fifth year following the adoption of this amendment in order to certify the accuracy of the judicial district representation on the Board of Trustees.
At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.	Same

Disapproved (page 408)

Exhibit #2

Bylaws

Chapter V — Procedure of Election

Section 1 — Nominating Committee

Current	*Proposed*
(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.	(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, *from* its elected delegates, *members and an equal number of alternates to* the Nominating Committee *for* the next annual meeting of this Society. *The Nominating Committee shall consist of at least one representative of each component society. A component society of five hundred (500) or fewer members shall be entitled to one (1) representative. Each component society shall be entitled to one (1) additional representative for each additional five hundred (500) members or fraction thereof.*
(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Commit-	(b) *Each* elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Commit-

tee, shall present his credentials to the Secretary at the close of the first session of the House of Delegates at the annual meeting.	tee, shall present his credentials to the Secretary at the close of the first session of the House of Delegates at the annual meeting.	(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.	Same
(c) The Immediate Past-President of this Society shall be the member of the Nominating Committee representing the Fellows. If he shall not be able to serve, then at the close of the first session of the House of Delegates, the Fellows shall elect one of their number to be a member of the Nominating Committee. He shall forthwith present his credentials to the Secretary.	Same	(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.	Same
		The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.	Same
(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.	Same		*Where a county has more than one representative to the Nominating Committee, the county may designate a senior representative who shall be spokesman for his delegation in the course of nominating and seconding of candidates, unless there be dissent, in which case a dissenting delegate shall be heard. In the actual balloting, each member of the Nominating Committee shall cast an individual vote.*

Section 2—Procedure of Nomination

Current	*Proposed*		
(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.	Same	The chairman shall have only the right to vote in case of a tie.	Same
		The secretary shall announce the result upon completion of each roll call. If the tabulation of any roll call be challenged by any member of the committee, the roll shall be called again. A majority vote of the members present shall nominate. In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. The call of the roll shall be repeated until a nomination is made.	Same
The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.	Same		

(d) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.	Same
(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.	(e) The election of Trustees shall conform to the provisions of the Constitution.

Not approved (page 409)

Exhibit #3

Bylaws

Chapter I — Membership
Section 2 — List of Members

Current	*Proposed*
(d) Not later than the first day of April in each year the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate to the Nominating Committee.	(d) Not later than the first day of April in each year the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate*(s)* and alternate*(s)* to the Nominating Committee.

Not approved (page 409)

Exhibit #4

Bylaws

Chapter VI — Rights and Duties of Officers
Section 5 — Board of Trustees

Current	*Proposed*
(f) State Board of Medical Examiners.	(f) State Board of Medical Examiners.
Acting for this Society, and in accordance with the statutes of the State of New Jersey, as vacancies occur in the State Board of Medical Examiners, the Board of Trustees shall nominate for each appointment three (3) members of this Society. The names of such nominees shall then be transmitted to the Governor of the State of New Jersey.	Acting for this Society, and in accordance with the statutes of the State of New Jersey, as vacancies occur in the State Board of Medical Examiners, the Board of Trustees shall nominate for each appointment *at least* three (3) members of this Society. The names of such nominees shall then be transmitted to the Governor of the State of New Jersey.

Approved (page 409)

Proposed Amendment to the Constitution

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1967 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote in 1968. In compliance with the constitutional provision regarding amendments, the proposal was sent to each component society under date of Febraury 1, 1968 and published in *The Journal* in January 1968 (page 26).

This proposed revision requires adoption by a two-thirds ($\frac{2}{3}$) vote of members of the 1968 House of Delegates present and voting at the final session.

Constitution

Article VI — Board of Trustees

Current	*Proposed*
The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members — at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and *elected Trustees* — at least two (2) from each judicial district *for a membership up to one thousand (1,000); each judicial district shall be entitled to one (1) additional Trustee for each additional one thousand (1,000) members, or major fraction thereof, computed as of December 31. The term of elected Trustees shall be for three* (3) years, such term to commence upon expiration of the term of the then incumbent.
Any member may be elected a Trustee for a maximum of three (3) full terms.	Same
At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.	Same

Adopted (page 408)

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")



The official programs and projects for 1967-68 were submitted to and approved by the Board of Trustees.

The work of the Auxiliary was so efficienctly planned and consummated that there was no need for a formal meeting of this Committee.

Since the programs for each county are of continuing nature, final reports have not been returned. So a complete summation at this time is not possible.

Among the many projects of the Auxiliary this year, those of outstanding interest were:

1) To make the auxiliary publication more readily identifiable with the medical profession, we changed the title on the masthead from the "New Jersey Newsletter" to *The Shingle*. This brought an approving response from the membership.

2) The Medical Student Loan Fund chairman reported that most of the bicentennial mementos have been sold, and the financial total will be presented in May.

3) The Health Careers chairman has been actively engaged in sending educational materials to each county and in encouraging health career programs. Several counties have had health forums.

4) One county has been outstanding in its work in "After Care for Drug Abusers." The same auxiliary purchased films called "L.S.D. — Insight or Insanity" and "Pit of Despair," which have been shown 87 times to church groups, youth groups, Lion's Clubs, and Rotary.

5) Drug samples, medical books, and leper bandages have been collected and will be sent to St. Raymond's center in New York for distribution overseas.

6) Many safety programs have been presented, and the safety chairman attended meetings of the New Jersey Safety Council.

7) To combat veneral disease, several counties have presented packaged programs on this subject in the schools.

8) Upon the recommendation of the Committee on Emergency Medical Care — approved by the Board of Trustees — the Auxiliary will help in promoting a "medical self-help training program" at the local level, with the approval of their county medical societies.

9) This year — upon the recommendation of this Committee, as volunteered by the Auxiliary and approved by the Board of Trustees — the Woman's Auxiliary will serve in an advisory capacity in seating guests of honor at the annual banquet.

It is with pleasure that the Committee again expresses appreciation to the officers and members of the Auxiliary for continued support of The Medical Society of New Jersey and for their cooperative efforts to protect and promote the art of medicine and the betterment of public health in New Jersey.

Approved (page 407)

Administrative Councils

Council on Legislation

Jesse McCall, M.D., Chairman, Newton
(Reference Committee "E")



The activities of the Council on Legislation — particularly the Society's position on current state legislation and bills signed into law — are regularly reflected in THE JOURNAL and *Membership News Letter*. In addition, the actions of the Council are regularly called to the attention of component societies through minutes of meetings of the Board of Trustees.

1967 Legislative Summary

At noon on January 9, 1968, the 191st (1967) session of the New Jersey Legislature adjourned *sine die*. A total of approximately 1,653 bills were introduced during that session. This is an increase of almost 100 over bills introduced in the preceding session. The Council took a position on 123 measures, as relevant to the Society's interest and concern. Of this total (1) 16 bills approved by MSNJ became law; (2) 3 bills disapproved by MSNJ became law; (3) one bill actively opposed by MSNJ became law; (4) eight bills on which the Society had a position of no action were signed into law.

Introduction of Legislation

Since June 21, 1961 — reaffirmed February 6, 1963 — it has been the policy of MSNJ, upon recommendation of the Council, not to introduce any new bills until some positive action has been taken by the Legislature with regard to the medical/x-ray technicians' bill. The Council concluded that the policy decision has not proved to be practical — at least for the present. Upon recommendation of the Council, this policy decision was rescinded, and the Board empowered the Council to introduce measures according to its appreciation of the priority of importance and the timeliness of such introduction. With the reorganization and expansion of the New Jersey Legislature this year, the Council agreed that all Society-sponsored legislation awaiting introduction should be processed at the earliest possible time. Individual component societies were requested to arrange for introduction of Society-approved legislation by their local legislators, when such societies were the original movers of the legislation involved.

Utilization Review Committee Immunity

Referred to the Council was Resolution #12, adopted by the 1967 House, which directed that MSNJ seek passage of state legislation which would provide for a physician who serves on a Utilization Review Committee immunity from litigation arising from actions of the committee. The Council prepared the draft, which the Board approved. Through the efforts of the Essex County legislative keymen, the measure was introduced by Senator James H. Wallwork(R) of Essex County on March 14 as Senate Bill 526. A similar bill was introduced in the Assembly (A-524).

Prohibition of Advertisements

Referred to the Council was Resolution #22, adopted by the 1967 House, which directed that MSNJ draft appropriate legislation prohibiting certain types of advertising for members of allied health professions and services. The Council prepared the draft, which the Board approved, and the Monmouth County Medical Society agreed to effect its introduction. On March 26, this legislation was introduced as A-549 by James M. Coleman, Jr. (R), Louis R. Aikins (R), and Chester Apy(R) of Monmouth County. Allied health professions have been requested actively to support this measure.

Medical/X-Ray Technicians

The Council revised since last year its draft of legislation to afford legal protection to medical/x-ray technicians who carry out procedures on patients at the specific directions of licensed physicians. The Burlington County Medical Society effected the introduction of this measure. On March 18, Senator Edwin B. Forsythe (R) President of the Senate, introduced the bill. It is S-589.

Privileged Communication

In accordance with the Board's directive that a draft of legislation to extend "privileged communication" to physicians be introduced at the earliest possible time, representatives of the Council met with various legislators. Senate Bill 274 was introduced on January 15 by Senators Woodcock (D), Ridolfi (D), and Coffee (D), The measure is almost identical to a draft proposed by the Society several years ago. It has the active support of the Society.

School Examination Law

The Council revised its original draft — as a result of a directive from the 1958 House — to amend current law so as to authorize a school medical inspector to accept report of a physical examination performed by a licensed physician in lieu of the presently required school examination. Bills have in the past been introduced for the Society by Senator Ridolfi in 1959 (S-147), 1961 (S-66), 1962 (S-204). The Bergen County Medical Society — an original proposer of the 1958 resolution — has agreed to effect the introduction of this revised measure.

Pre-employment Physicial Examination

The Council reviewed its draft — as the result of a directive from the 1964 House — to amend that section of current law requiring that pre-employment physical examinations on persons under 18 be performed only by a medical inspector employed by a board of education. Through the cooperation of the Sussex County legislative keyman, the Society's draft was introduced as A-511 on March 18 by the following: Robert E. Littell(R) and Douglas E. Gimson(R) of Sussex, Warren, and Hunterdon Counties; James S. Cafiero(R) and James R. Hurley(R) of Cape May and Cumberland Counties; and Charles J. Irwin(R) of Union County.

Entertainment Hypnosis

The Council reviewed its draft — as the result of a directive from the 1960 House — to prohibit entertainment hypnosis. Similar legislation has previously been supported by the Society in 1963, 1964, 1965, and 1966. The Ocean County Medical Society will support the introduction of this measure.

Unincorporated Business Tax

During the past year, MSNJ has participated with other professional organizations of New Jersey in a campaign to achieve unified action in an endeavor to repeal Chapter 137 of the laws of 1966. The 1967 House — by adoption of Resolution #27 — directed that "The New Jersey Legislature be urged to repeal Chapter 137, Public Law of 1966." The campaign was directed toward outlining repeal of the new tax law, or failing that, to postponement of the effective date and the elimination of chief inequities. At the present time, the Society has registered its approval of Senate Bill 200, to repeal the gross receipts tax on unincorporated businesses.

Specialty Societies

As reported last year, each specialty society has been invited to send a representative to those meetings of the Council in which legislation affecting their interests may be considered. From experience, however, the Council has found that it is not always possible to ascertain sufficiently in advance of the meeting which specialty societies might be affected. Therefore, the Council has extended an invitation to every specialty society to designate, if it so desires, a representative to attend all regular meetings of the Council.

National Legislation

In accordance with precedent, the Council is

guided on the national legislative scene by positions and recommendations of the American Medical Association. Among the significant measures at national level to which the Council this year gave its attention are the following: amendment to the comprehensive health planning act (HR #6418), social security amendment (HR #12080), payment to chiropractors under part B of Medicare (HR #5780), proposed compulsory generic prescribing law.

The significant social security amendments under the Medicare Bill were reported to the members through the *News Letter*.

Current State Legislation

In the afternoon of January 9, the 192nd (1968) session of the State Legislature was opened. As the result of reapportionment of the Legislature and the last November election, the roster of New Jersey Legislators for 1968 differs markedly from those of preceding years. As the Legislature presently is constituted, the Senate has a total of 40 members (31 Republicans, 9 Democrats) and the Assembly has a total of 80 members (59 Republicans, 21 Democrats). By means of official legislative bulletins, the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, county society secretaries, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active support . . . all-out support for the measure

Active opposition . . . all-out opposition to the measure

Approved . . . commended as satisfactory, but not actively supported

Disapproved . . . rejected as unsatisfactory, but not actively opposed

No action . . . considered, but not regarded as significant or relevant to the proper interests of the Society

All measures thus marked (*) are identical with bills of last year — or preceding years — and the Society's position concerning them is the same.

*S-119—To provide for the educaion of students in the medicine and dentistry professions. *APPROVED*

*S-138—To direct the Department of Institutions and Agencies to determine upon a program and plan to provide medical assistance for the needy in accordance with social security programs providing old age assistance, aid to the blind, aid to dependent children, and aid to the disabled. *APPROVED*

*S-153—To authorize the trustees of the New Jersey College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *NO ACTION*

*S-159—To prohibit littering of waterways and adjacent shoes and beaches and to regulate marine toilets. *APPROVED*

*S-186—To provide for a "State Uniform Dog Control and Licensing Act." *DISAPPROVED,* because of its many undesirable provisions, but chiefly because it would unjustifiably transfer a basic public health program — the prevention of rabies in humans and animals — and its supporting funds, from the Department of Health, which has long been administering the program with eminent success, to the Department of Agriculture.

*S-187—To provide for increases in maximum weekly workmen's compensation benefits for permanent partial disabilities, increases in funeral allowances, free choice of physician, a Board of Workmen's Compensation Appeals, and other changes. *NO ACTION*

Amended to "Approved," in recognition of the fact that S-187 would afford free choice of physicians to those covered under Workmen's Compensation. (page 400)

*S-188—To provide for the licensing and registration of electrologists by the Board of Medical Examiners. *APPROVED*

*S-192—To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes, or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

*S-200—To repeal the tax on gross receipts of unincorporated businesses. *APPROVED*

*S-216—To provide for civil commitment of drug addicts. *APPROVED*

*S-217—To provide that any applicant for a license to practice medicine and surgery who, licensed in another state, in addition to other required proofs necessary to be admitted to examina-

tion, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED,* because it would abrogate the present discretionary powers of the Board on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

S-223—To provide increased penalties for violations of the narcotics drug act and to provide that such penalties shall not be remitted nor shall any person sentenced thereunder be eligible for parole. *APPROVED*

*S-246—To require medical service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member, or employee covered under contracts. *APPROVED*

*S-247—To require hospital service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member, or employee covered under contracts. *APPROVED*

S-274—To provide for those confidential communications between physician and patient which are and which are not privileged under "The Evidence Act, 1960." *ACTIVE SUPPORT*

*S-314—To provide that the Commissioner of Institutions and Agencies in committing sex offenders shall not recommend commitment to an institution other than one providing entirely separate facilities for confinement of persons convicted of offenses listed in Section 2A:164-3 of the Revised Statutes. *APPROVED*

S-334—To provide that the implied warranty of merchant-ability under the Uniform Commercial Code shall not apply to sale of blood banks or tissue or organ reservoir; to provide that these shall be considered medical services. *ACTIVE SUPPORT*

*S-335—To provide a penalty of imprisonment for not
*A-160—less than two years for persons addicted to narcotics who use any child under 18 years of age to transport or sell narcotic drugs. *APPROVED*

*S-336—To forbid suspension of sentences for illegal
*A-159—manufacture or sales of narcotic drugs. *APPROVED*

S-337—To provide penalties for first, second, and
A-158—third offenses of violations of the Narcotics Drug Act. *APPROVED*

S-338—To provide that any special arrangements for for the burial of a human body that was made available for the advancement of medical science shall be the sole responsibility of the person entrusted to control the disposition of the remains of the deceased person and not of the receiving agency. *APPROVED*

*S-354—To provide immunity under the Good Samaritan Act to any person who extends emergency aid. *DISAPPROVED,* because it would expose victims of accidents to serious danger in consequence of well-meant but incompetent ministrations that could do more harm than good.

*S-362—To provide for reimbursement for licensed chiropractors' services under any group accident, group health, and group accident and health policy or contract. *DISAPPROVED,* as unnecessary, since the chiropractor is already entitled to payment for services rendered under any insurance policy which covers chiropractice services.

*S-363—To provide that licensed chiropractors shall have the same privileges and benefits as licensed physicians and surgeons under the act governing medical service corporations. *DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES,* because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. Chiropractors are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

*S-364—To provide for reimbursement for licensed chiropractors' services under accident and sickness insurance policies. *DISAPPROVED,* as unnecessary, since the chiropractor is already entitled to payment for services rendered by him under any insurance policy which covers chiropractic services.

*S-365—To provide that the services of a chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy, or under any labor management trustee, union welfare, employee benefit, or any private insurance or welfare plans. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because chiropractors receive a limited license to practice chiropractice.

*S-369—To authorize acquisition of the Jersey City
*A-300—Medical Center for use by the New Jersey College of Medicine and Dentistry. *NO ACTION*

S-382—To provide for the distribution of a supply of fluoridated tablets by the Department of Health where applied for by a Board of Health of any county when any child under 9 shall request same on an application signed by the parent or guardian of the child. *DISAPPROVED,* because it is impractical of implementation, since there is in New Jersey only one county board of health established by statute (Hudson).

S-419—To provide that the first returns under the Unincorporated Business Tax Act shall be filed on or before November 1, 1968 for calendar year taxpayers or on the basis of fiscal year ending June 15, 1968; and on or before the fifteenth day of the fourth month following close of a fiscal year ending after June 15, 1968. *APPROVED*

*A-11 —To include carbon tetrachloride in the phrase defining "glue." *APPROVED*

*A-16 —To establish presumptions in certain illnesses of firemen and policemen. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-56 —To provide that information to the State Board of Medical Examiners by applicants for examination shall include a declared intention to become a citizen of the United States. *APPROVED*

*A-90 —To repeal the gross receipts tax on unincorporated businesses. *APPROVED*

*A-100—To provide that alcohol in excess of 0.05% but less than 0.10% in a motor vehicle operator's blood shall not give rise to a presumption that his driving ability was or was not impaired by consumption of alcohol. *APPROVED*

*A-132—To repeal the tax on gross receipts of unincorporated businesses. *APPROVED* . . . . . .

A-158—To increase penalties for violations of the nar-
S-337—cotic drugs act and to include as a violator anyone who manufactures any medicinal preparation in violation of the act. *APPROVED*

*A-159—To provide that any person who employs or
*S-336—uses a child under 18 years of age to transport or sell narcotic drugs shall be imprisoned for not less than 20 years with a maximum imprisonment of life. *APPROVED*

*A-160—To provide penalties where narcotic addicts
*S-335—use anyone under 18 years of age to carry, sell, or prepare for sale narcotic drugs. *APPROVED*

A-161—To exempt from the Sales and Use Tax Act sales of any air pollution equipment facility or device certified by the Commissioner of Health. *APPROVED*

A-196—To increase the minimum imprisonment for narcotics drug violations to 15 years. *NO ACTION* . . . measure much too extreme.

*A-203—To establish a Medical and Dental College of South Jersey as an affiliate of Rutgers University. *APPROVED*

*A-215—To require the Commissioner of Banking and insurance to conduct a complete examination of hospital service corporations and hospitals with whom contracted before approving schedules of rates to be paid by subscribers. *DISAPPROVED,* because, although MSNJ approves the recommendation of the Governor's Commission to investigate Blue Cross that an audit under official auspices should be established and maintained, the Society is convinced that such audit should not be limited to the time of application for subscriber's rate increase.

*A-231—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it involves diagnosis by legislative enactment rather than by medical investigation.

A-270—To exempt sales of air pollution control machinery, equipment or apparatus from the Sales and Use Tax Act and to provide that such exemption shall not apply to air pollution control equipment attached to motor vehicles. *DISAPPROVED,* because it is discriminatory against the owners of motor vehicles.

A-271—To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of any industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

*A-272—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

*A-277—To provide immunity from civil damage suits to volunteer first aid or rescue squad workers who are not members of a volunteer fire company. *APPROVED*

*A-278—To provide for suspension, revocation or prohibition of motor vehicle licenses for persons convicted under the uniform narcotic drug law. *NO ACTION*

*A-290—To provide that no person shall deliver to any consumer potable water which does not conform to the standards for potable water of the State Department of Health as established by regulation; to place supervision of all water supply systems in the Department with respect to the quality, protection, and maintenance of adequate pressure and volume of the supply of potable water furnished. *APPROVED*

A-293—To authorize a municipality with a population of 400,000 or more to acquire up to 50 acres of real estate where a State operated college of medicine and dentistry is located or proposed to be located. *NO ACTION*

*A-300—To authorize the Board of Trustees of the
*S-369—New Jersey College of Medicine and Dentistry to acquire the Jersey City Medical Center. *NO ACTION*

Supplemental Report

The Council on Legislation held a meeting on March 28. Its recommendations will be acted upon by the Board of Trustees at its meeting on April 21. The Council is also scheduled to meet in early May. The results of these meetings will be the basis for a supplemental report to the House, to bring the members up to date on current state legislation.

Approved as amended with commendation to the Chairman, members of the Council, and assisting staff for a job well done. (page 400)

Supplemental Report #1

At its April 21 meeting, the Board of Trustees considered recommendations from the Council's meeting of March 28. Thus does the Council submit this Supplemental Report #1, which has been compiled since the preparation of our annual report.

The Council is scheduled to meet next on May 9. The results of that meeting will be the basis for Supplemental Report #2 to the House, which will be distributed in Atlantic City.

Model Ambulance Service Ordinance

The Board approved the recommendation of MSNJ's Committee on Emergency Medical Care that, "the Society endorse the model ordinance regulating ambulance service and urge that all necessary steps be taken to enact it into law in New Jersey as soon as feasible and practicable," and referred it to the Council for investigation and report on the proper procedure for introducing this legislation.

The Council concluded that enactment of the model ambulance ordinance into law must be done piecemeal to take care of all the relevant statutes affected.

Current State Legislation

The following list presents the official position of MSNJ regarding additional bills currently in the Legislature. Those measures thus marked (*) are identical with bills of last year — or preceding years — and the Society's official position concerning them is the same.

*S-397—To provide that no hospital or medical service corporation or insurance company shall be entitled to be subrogated to any claim or an insured as against any third party other than the employer of the insured or the employer's carrier or any hospital or physician's lien except payments made under the Workmen's Compensation Law. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey.

S-434—To authorize the Department of Health to
A-371—make a study of pre-packaged foods and food products, and to determine the practicability of requiring containers to be marked with a date on which they were filled. *DISAPPROVED,* because the measure is impracticable. MSNJ strongly favors all measures that would effectively protect the public interest. This measure, however, the Society deems impracticable.

S-436—To require packaging of fresh meat in entirely transparent containers. *NO ACTION*

*S-444—To provide that any person who distrains or impounds any stray dog or cat with the intention of selling such animal for animal experimentation is a disorderly person. *DISAPPROVED,* because it would prevent the use of any impounded dog or cat for purposes of animal experimentation, with consequent immense disservice to scientific research for the benefit of mankind.

S-450—To provide for the establishment of dental health plans subject to approval of the Commissioner of Banking and Insurance. *NO ACTION.*

S-461—To require all manufacturers of stuffed toys to register with the Department of Health; to regulate the manufacture, sale, gift, and distribution of stuffed toys. *NO ACTION,* because MSNJ considers S-506 a more satisfactory measure.

*S-464—To provide for the establishment of a Medical
*A-203—and Dental College of South Jersey by Rutgers University. *APPROVED*

S-469—To exempt law and medical libraries of attorneys and of physicians and surgeons from assessment and taxation as personal property used in business. *APPROVED*

S-506—To define, under the Hazardous Substances Labeling and Sales Act, the term "label" as applied to an unpackaged article; the term "misbranded package" to include a child's toy; and to provide a definition for "banned hazardous substance." *APPROVED* (See S-461)

S-508—To permit licensing of non-citizen applicants
S-571—who have declared their intention of becoming United States' citizens by the State Boards of Certified Public Accountants, Dentistry, Mortuary Science, Medical Examiners, Shorthand Reporting, Veterinary Medical Examiners; and the New Jersey Real Estate Commission. *NO ACTION,* because MSNJ is on record as supporting A-56 — which has been signed into law — a related measure dealing exclusively with the practice of medicine.

S-526—To provide for the confidentiality of information and data secured by, and in possession of, hospital or extended care facility utilization review committees. *ACTIVE SUPPORT,* with suggestion for amendment to include the desirable elements of A-524, a similar measure.

*S-538—To provide for public representation on all professional boards. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because professional unqualified lay members would encumber the boards, with no appreciable advantage to the public.

S-546—To provide that the consent of minors to treatment for venereal disease shall be valid and binding. *ACTIVE SUPPORT*

S-557—To provide that any applicant for a chiropractic license must have completed no less than one and one-half years of study in accredited school or college of arts and sciences before commencing study in the approved school of chiropractic. *NO ACTION*

S-564—To provide additional medical-surgical and major medical insurance in the State and School Employees' Benefit Plan. *APPROVED* (See A-87)

S-578—To authorize the chief executive officer of a
A-526—state or county institution for the mentally ill or retarded, or of a state or county penal or correctional institution, to give consent for treatment of incompetent patients or inmates under 21. *APPROVED*

S-583—To provide facilities for the physically handicapped in public buildings; to provide for promulgation of guidelines by the State Board of Architects under standards of the American Standards Association, Inc. *APPROVED*

S-589—To authorize certain persons to assist physicians or surgeons in providing limited auxiliary technical procedures. *ACTIVE SUPPORT*

S-594—To provide a penalty for a person who operates a motor vehicle while under the influence of marijuana. *APPROVED*

A-87 —To provide increased Blue Cross and Blue Shield benefits (Rider J) for public and school employees. *NO ACTION*, because MSNJ considers S-564 a better measure.

A-102—To establish a Board of Hearing Aid Dispensers; to provide for regulation, examination, and licensing of persons who dispense and fit hearing aids. *APPROVED*

A-307—To permit the State Board of Control of the Department of Institutions and Agencies to assess penalties for violations of rules and regulations concerning care of patients in convalescent homes, private nursing homes, and private hospitals. *APPROVED,* with the understanding that "private" means "proprietary."

A-349—to provide for the licensing and regulation of convalescent and nursing home administrators. *APPROVED*

A-367—To provide that any person who purchases or attempts to purchase alcoholic beverages for a minor is guilty of a misdemeanor. *DISAPPROVED,* because the measure is so broad in its scope as to be impracticable of implementation and because it invades the privacy of the home and certain religious observances.

A-374—To exempt from the sales tax recognized nonprofit or civic associations or clubs. *NO ACTION*

A-389—To increase the annual reimbursement grants from State funds for all community health projects, except capital expenditures, from $0.25 to $0.50 for all counties multiplied by the population of that county. *APPROVED*

A-403—To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefore. *DISAPPROVED,* because the measure does not satisfactorily deal with the problem of controlling narcotic addiction and overrides the discretionary powers of the judiciary.

A-405—To establish a Department of Narcotic and Drug Abuse Control as a principal departmental in the Executive Branch of State Government. *APPROVED*

A-464—To provide for a refund or credit of Sales and Use Taxes paid for the purchase and installation of air pollution abatement equipment, certified as such by the Commissioner of Health, and on services rendered thereon where such equipment is purchased on or after April 1, 1968. *APPROVED*

A-469—To permit the Department of Health to exempt incinerators which by type and size, in their opinion, should not be subject to the licensing requirements of the solid waste disposal act. *APPROVED*

A-488—To increase penalties for violations of the narcotic drugs act; and to provide for the examination of suspected narcotic and drug addicts by two qualified physicians upon court initiative or request of counsel for the defendant. *NO ACTION*

A-497—To provide for determination of potable water standards by the Department of Health; to provide for hearings prior to adoption of such standards. *APPROVED*

A-503—To exempt sales of over-the-counter drugs from the Sales and Use Tax Act. *APPROVED*

A-504—To define a "depressant or stimulant drug" to include any hallucinogenic drug — including d-lysergic acid diethylamide (LSD), n-n-dimethyltryptamine (DMT), psilocybia, mescaline, peyote, bufotenin, epena, parua, ayahuasca, yage, caapi, amaneta, muscaria, and, other substances; and to provide penalties. *APPROVED*

A-511—To provide that a statement of physical fitness of a minor seeking employment may be signed by any physician licensed to practice medicine and surgery. *ACTIVE SUPPORT*

A-524—To provide for the confidentiality of information in possession of hospital or extended care facility ntilization review committees. *ACTIVE SUPPORT* (See S-526)

A-549—To prohibit solicitation of patients by persons licensed or registered to diagnose or treat human illness or deformities and to prohibit such solicitation or advertising by any agency or association on behalf of such persons. *ACTIVE SUPPORT*

A-639—To except ophthalmic assistants from certain prohibitory provisions of Charpter 9, Title 45, of the Revised Statutes concerning the practice of medicine. *APPROVED,* provided the term "ophthalmic" assistant is amended to read "ophthalmological" assistant, and a a statement is appended to the measure which will set forth the background and necessity in the public interest for this measure.

Approved (page 400)

Supplemental Report #2

At its meeting last evening (May 17), the Board of Trustees considered recommendations from the Council's meeting of May 9. Thus does the Council submit this Supplemental Report #2, to bring the House up to date on current state legislation.

Current State Legislation

The following list presents the official position of MSNJ regarding additional bills currently in the Legislature.

S-520—To provide for licensing of any applicant for a license to practice medicine and surgery who can establish he has been examined and licensed by certificate of the National Board of Examiners for Osteopathic Physicians and Surgeons. *APPROVED*

S-532—To increase the podiatry pre-professional academic education requirements from one to two years; to permit the Medical Board to recognize the examination given by the National Board of Podiatry examination; and to remove the requirement for a Podiatry Student's Qualifying Certificate certifying pre-professional education. *APPROVED*

S-607—To provide for inspection of public and private facilities for care, treatment, and discipline of children. *APPROVED*

S-617—To provide that medical records or photographic reproductions shall be retained by a hospital for 7 years following the most recent discharge of a patient or until the confined person reaches age 23, whichever is later; to require retention of a discharge summary sheet for 20 years and x-ray films for 5 years. *APPROVED*

S-646—To provide for the uniform control and licensing of dogs, and the handling of dogs and other animals; to repeal Chapter 151, P.L. 1941. *NO ACTION*

S-655—To provide that the prohibitory provisions of the act concerning the licensing of physicians shall not apply to employees of a municipal hospital. *APPROVED*

S-682—To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *APPROVED*

S-698—To provide for the construction of a Community Mental Health Center to be managed by the New Jersey College of Medicine and Dentistry. *APPROVED*

S-703—To provide that milk containers shall be legibly marked in dark ink with the day pasteurized. *NO ACTION*

S-718—To provide, under contract with the Rutgers Center of Alcoholic Studies, for a study and pilot facility involving problems of the chronic drunkenness offender. *APPROVED*

S-722—To create a Physical Therapy Examining Board; to prescribe its membership and functions; to define "physiotherapy;" to provide for registration of physical therapists. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because present statutory arrangements — which give to the Board of Medical Examiners of New Jersey the right and responsibility to make official determination and identification of qualified physicial therapists — is more protective of the public interest.

S-723—To provide for additional contributions by municipalities to the pension fund of police and firemen; to define "child" to include one who is mentally retarded or physically incapable of performing any substantial or gainful employment. *NO ACTION*

A-530—To provide that no hospital service corporation shall refuse to renew a subscriber's contract after one year of issue except for fraud, moral hazard, discontinuance of class of policies, and other reasons approved by the Commissioner of Banking and Insurance. *NO ACTION*

A-585—To provide that any incorporated non-profit association, organization, league, society, or other group created to protect dumb animals shall have the same rights, powers, and privileges vested in the Society for the Prevention of Cruelty to Animals. *DISAPPROVED,* Because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed — or is failing — to perform its responsibilities in enforcing those laws.

A-601—To provide that the act regulating employment of child labor shall not apply to minors 16 years of age or over doing public first-aid or rescue squad duty as members of any volunteer first-aid or rescue squad. *APPROVED*

A-604—To provide for confidential communications between physicians and patients which shall be considered privileged and not privileged under the Evidence Act. *APPROVED*

A-618—To provide for the periodic re-examination by the Director of Motor Vehicles of the physical fitness of persons of age 40 or more to operate motor vehicles for renewal of a driver's license. *DISAPPROVED* as impractical, because it would rely upon the medical profession for manpower which it cannot supply; would be financially oppressive for an end that will be limitedly useful; and would provide no circumstancial guarantee that, once examined, a person's physical fitness would continue for three years.

A-619—To require every physician, after determining that a person holding a learner's permit or a driver's license is suffering from a stroke or physical injury which impairs his operation of a motor vehicle, to report such to the Director of Motor Vehicles within 72 hours, and to require the Director to provide for temporary suspension of driving privileges. *DISAPPROVED* as too extreme in that, without

regard to recurrence or duration of limited incapacitations, it would expose many drivers to immediate suspension of driving privileges for periods that could unfairly jeopardize their ability to pursue their livelihood.

A-629—To establish a bureau of river pollution control in the Department of Health. *NO ACTION*

A-630—To authorize two or more municipalities to establish regional river pollution control commissions. *NO ACTION*

A-631—To establish penalties for violations of the motor vehicle laws where a person is convicted of violations while under the influence of alcohol, or narcotic or habit producing drugs. *NO ACTION*

A-654—To authorize medical service corporations to issue benefits for health care services, other than medical services, as approved by the Commissioner of Banking and Insurance. *NO ACTION*

A-655—To authorize hospital service corporations to issue additional health care services as approved by the Commissioner of Banking and Insurance. *NO ACTION*

A-660—To provide for the regulation and certification of x-ray technicians and to establish an x-ray technician board as an agency of the Commission on Radiation Protection in the Department of Health. *APPROVED*

A-670—To provide that no municipality providing water for public and private uses shall treat such water supply with fluorides unless such treatment is first authorized by the voters. *APPROVED*

A-689—To require ophthalmic dispensers to hold a high school diploma or the equivalent in order to qualify for examination and certification. *APPROVED*

A-693—To provide that no dog or other animal caught and detained shall be sold or otherwise made available for the purpose of experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-702—To appropriate $200,000 for establishing laboratory facilities in the Division of State Medical Examination. *APPROVED*

Epileptiform Seizures

Referred from the Board to the Council for study and recommendation was a draft of legislation which the Special Committee on Seizures — with the approval of the Council on Mental Health — proposed, to bring about repeal of the current law governing physicians' reporting of epilepsy as contained in the Revised Statutes 26:5-1. The Council unanimously approved a revised version, which it has returned to the Council on Mental Health for its consideration and concurrence.

Legislative Analyst

The Council unanimously adopted a vote of commendation of and confidence in the Legislative Analyst for his consistently distinguished work in behalf of the Council and MSNJ.

Society-Sponsored Legislation

Following is the present status (as of the May 13 session) in the Legislature of Society-sponsored legislation.

1. Medical technicians (S-589) . . . in Senate Committee. At its meeting last evening, the Board approved — upon recommendation of the Council — amendments to S-589. With the approval of the Radiological Society of New Jersey, the taking of x-rays will be deleted from S-589; and at the suggestion of the New Jersey Hospital Association, the statement of the bill will be amended. The Council likewise voted not to insert "and routine procedures," which was requested by the Academy of Ophthalmology and Otolaryngology.

2. Advertising by persons licensed or registered to diagnose or treat human illness (A-549) . . . passed in the Assembly.

3. Confidentiality between physicians and patients (S-274) . . . passed in the Senate; in Assembly Committee.

4. Declaration of intent to become a citizen (A-56) . . . Signed into law — Chapter 16, P.L. 1968.

5. Pre-employment physical fitness of a minor (A-511) . . . in Assembly Committee.

6. Utilization review committee (S-526) . . . in Senate Committee. The Board approved — upon recommendation of the Council — amendment to S-526 suggested by Hospital Service Plan of New Jersey.

7. School examination by medical inspectors . . . not yet introduced.

8. Prohibition of entertainment hypnosis . . . not yet introduced.

Approved (page 400)

Council on Medical Services

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committe "F")



The Bylaws state: "The function of the Council on Medical Services shall be to study and evaluate matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, to investigate matters pertaining to the economic and social aspects of medical care, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of medical service." The Board of Trustees has added to the functions of the Council on Medical Services overall responsibility to study and provide recommendations concerning (a) all aspects of the Medicare and Medicaid programs as they operate or will operate in New Jersey; and (b) the maintenance of quality medical care.

In fulfilling these assigned functions, the members of the Council on Medical Services have been very active in the past year. The following report will give in detail the work of the Council during the past year.

Physicians' Complaints Against Workmen's Compensation

The Council again considered the repeated complaints by member-physicians that under Workmen's Compensation their fees were being arbitrarily reduced for services to state employees.

This matter had been referred to Legal Counsel for report to the 1967 House. The Council was unanimous in its opinion that the report of Legal Counsel does not seem to have fulfilled the recommendation of the Council. The Council, therefore, unanimously recommended and the Board of Trustees approved as amended the following *recommendation:*

That the Board of Trustees direct Legal Counsel to take up this matter directly with *the office of* the Attorney General.

Approved (page 402)

Articles on Rehabilitation

At its June 25 meeting, the Board of Trustees was unanimous in its opinion that compilation in booklet form, as urged by the Council, of the series of articles on "Rehabilitation of the Injured Worker" which appeared in *The Journal* did not justify the expense of compilation in booklet form. At that meeting the Board of Trustees directed that through the *Membership News Letter* a reminder that the articles were published in *The Journal* and reference to the appropriate issues be made. This was accomplished in the September 1967 issue of the *Membership News Letter.*

Approved (page 402)

Referral from the Board of Trustees

The Council considered a referral from the Board of Trustees concerning the problem of utilization of physicians' services under Part B of Medicare. Documented evidence was studied. To alleviate some of the problems presented, the Council was of the opinion that a screening committee should be established at state level to review those cases which seemed to involve areas of questionable professional conduct. If such a screening committee should find a reasonable basis for a claim of unethical or unprofessional conduct in the matter referred by the fiscal intermediary, a complaint would be filed by the screening committee with the judicial committee of the component society having jurisdiction over the physician in question. The Board of Trustees approved the following

recommendations, subject to the concurrence of the House of Delegates.

(1) That a Committee be set up on State level to screen those cases which the fiscal intermediary feels may involve a question of medical ethics or professional conduct under Part B of Medicare.

(2) That the screening committe consist of five members to be appointed by the Board of Trustees, one from each of the Judicial Districts of The Medical Society of New Jersey, with a representative from Prudential Insurance Company (the fiscal intermediary for Part B of Medicare) as a consultant.

Not Approved (page 403)

Following recommendations of the reference committee approved as amended by the House:

(1) That any component society which does not have a utilization committee establish such committee and encourage it to be active and diligent in dealing with this problem; and

(2) That the fiscal intermediary be advised that it should file a complaint with the proper committee of the component society—utilization or judicial committee—when it feels (after due consultation with its medical consultants and advisors) that such action is indicated (page 403)

Title XIX in New Jersey

In July a meeting was held with representatives from the Council, the Commissioner of Institutions and Agencies, and selected members of his staff. As a result Doctor Benz and Mr. Vincent Maressa are acting as Liaison to the Department of Institutions and Agencies on Title XIX. The Commissioner has recently reiterated that the Council will be asked to take an active part in drafting the enabling legislation.

The Council reviewed in detail the Board of Public Welfare Recommendations to the Board of Control relating to a Title XIX Program in New Jersey, which was distributed on December 6, 1967. The Council was unanimous in the decision that the recommendations were acceptable with the following stipulations: that any remedial or medical care must be furnished by practitioners licensed in New Jersey, that chiropractic be excluded, and that physicians be paid their usual and customary fees. This position was subsequently communicated to the Commissioner of Institutions and Agencies over the signature of the Executive Director.

Resolution #11 of the 1967 House of Delegates contained four elements for MSNJ active support in enacting Title XIX in New Jersey. The Council has communicated to the Legislature the resolution of the House of Delegates concerning Title XIX. On March 22, 1967, John F. Kustrup, M.D., President-Elect, testified before a joint meeting of the Senate and Assembly Committees on Institutions and Welfare. Doctor Kustrup pointed out that The Medical Society of New Jersey strongly recommended inclusion of the following elements in New Jersey's Medicaid Program:

(1) The beneficiaries under the program should be assured free choice of physicians and hospitals.

(2) Physicians should be free to administer treatment and prescribe medications in conformity with their best professional judgement and in conformity with their legal responsibility for the welfare of the patients under their care.

(3) Payment for physicians' professional services should be on the basis of their usual and customary charges.

(4) The option should be available to physicians to bill directly to the patient, or to the agency or insurance carrier.

(5) A qualified insurance carrier should be designated to process claims and payments for charges for medical services.

Approved with the following recommendations:

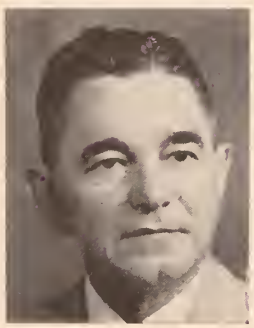
(1) That the Board of Trustees of MSNJ take steps to create a joint committee with the State Department of Institutions and Agencies for the purpose of discussing all aspects of Title XIX legislation in New Jersey, and that this committee be encouraged to confer with the legislators as often as necessary in order to insure that just and fair legislation be enacted; and

(2) That, should it prove necessary, a special session of the House of Delegates be called to consider aspects of Title XIX legislation in New Jersey (page 403)

Sub-Committee of the Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committe "F")



The Committee held a meeting to establish a more significant rapport with the New Jersey Workmen's Compensation Commission and the New Jersey Rehabilitation Commission (through Director Koransky, Judge Napier, Mrs. Holderman, and Dr. Jarvis Smith, all of whom were present). The Committee benefited from a lengthy discussion on the many areas of concern to both the state agencies and the Medical Society. This discussion afforded the members of the Committee the opportunity to discuss freely their opinions of the programs as conducted by these state agencies. It also afforded opportunity for the representatives of these agencies to respond with the comments of explanation on the programs and functions of these agencies.

Approved (page 403)

Insect Sting First Aid Kit Available

An Insect Sting First Aid Kit for emergency treatment of hyper-sensitive patients has been announced by Center Laboratories of Port Washington, New York. Available only through physician's prescriptions, the Insect Sting First Aid Kit is designed to provide immediate treatment for patients who have been stung by bees, wasps, hornets, or yellow jackets. It has been noted that each year more people are killed by bee stings alone than by all the snakes and reptiles put together. The prime stinging offenders are the yellow jacket, the bee, the wasp, and the hornet, all members of the class hymenoptera, and all widely distributed across the United States. The first sting may sensitize and subsequent stings may produce severe reactions. For such hypersensitive persons, immediate aid is imperative. The Insect Sting First Aid Kit is designed to provide such immediate aid. Compact and easy to carry, the kit can be slipped into a purse, picnic box, or lunch box; or even carried in a shirt pocket. It can be utilized quickly in an emergency situation until a hospital or physician can be reached.

Each of the new kits contains a pre-loaded syringe containing epinephrine 1:1000, two types of tablet medication, a tourniquet, a sterile alcohol pad, Medic-Alert emblem literature, complete instructions for use, plus printed suggestions for avoiding stinging insects. Available by prescription, at local drug stores. Each kit costs $4.50. For more details, write to Center Laboratories, 5 Channel Drive, Port Washington, New York 11050.

Council on Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead
(Reference Committee "G")



This, the first year of the Council on Mental Health, found a few post-natal difficulties that had to be met promptly; but generally speaking, progress was considered to be better than satisfactory for our initial enterprise.

Our first organizational meeting found the Council concluding that five special committees, for the time being, were ample to launch our efforts. These were Special Committees on Mental Retardation, Seizures, Drug Addiction, Alcoholism, and Emotional Disorders of Childhood and Adolescense. We then prepared a set of charges to each of the special committees, outlining their specific duties, obligations, and anticipated achievements. Three of the five committees functioned very effectively and well, meeting quite frequently, although one was hampered to a considerable degree by a lack of attendance of its members. Another committee got a late start but accomplished considerable despite its tardiness, and the fifth committee seemed to have trouble getting off the ground. The Council is greviously concerned about the lack of attendance of several members appointed to these committees, although the attendance at the Council on Mental Health was excellent throughout its four meetings.

The Chairman of the Council was privileged to be one of ten individuals invited by the American Medical Association's Couucil on Mental Health to meet with a select committee in October. This day-long conference was an effort to devise new approaches whereby the American Medical Association Council on Mental Health could be of greater assistance to the State Society Councils on Mental Health. A number of suggestions from that conference were utilized at the 14th Annual Conference of Mental Health Representatives of State Medical Societies held in March 1968. This conference — titled, "Drug Abuse in the Now Generation" — was attended by the Chairman of the Council, as well as by several other members of our special committees who had interest in this area. It was a meaningful two days on updating medical attitudes on drug abuse, as well as enlightening us on current research and treatment programs underway throughout numerous university health programs and medical schools.

The Council also succeeded in preparing concise abstracts regarding mental health facilities in the Department of Institutions and Agencies, which are now being cleared by legal counsel preparatory to their publication in *The Journal* of The Medical Society of New Jersey for the enlightenment of all its members. It is hoped that these abstracts, after reading, will be removed by the members and filed in a convenient area for ready reference should questions arise regarding the need for psychiatric facilities throughout the State, as well as facilities for the mentally retarded, disturbed children, and the diagnostic center.

The reports of five of the Council's special committees will readily convey their individual accomplishments; and all members are encouraged carefully to review them. We are all intensely interested in improving our service to the Society and would welcome any suggestions or constructive criticism that we could act upon in the hope of offering more comprehensive service.

Approved (page 405)

Sub-Committees of the Council on Mental Health

Alcoholism

Henry J. Mineur, M.D., Chairman, Cranford
(Reference Committee "G")

At its organization meeting the Committee agreed to limit its activities to the support of educational programs pertaining to alcoholism when requested but not to initiate new programs.

The only matter referred to the Committee was the AMA Exhibit on Alcoholism for display at the 1968 annual meeting in Atlantic City. This is a self-contained, self-explanatory exhibit.

Approved (page 405)

Drug Addiction

Henry A. Davidson, M.D., Chairman, Cedar Grove
(Reference Committee "G")



Your special committee is, on the whole, somewhat discouraged with progress in the control of addiction in this country, and particularly in our state. We note several agencies — federal, state and county—all interested in the problem but poorly integrated in their efforts. Some of the "poverty" organizations are involved. So is a state council and a number of county advisory councils. Our penal institutions, state and county, are concerned. Both the State Health Department and the State Department of Institutions and Agencies are working in the field. Most of the probation officers have addicts among their charges. What is needed is, ideally, a single state agency; or, if that is not practical, better coordination of existing agencies.

Pioneer work, substituting methadone addiction for heroin addiction, is now going on at the New Jersey Neuropsychiatric Institute at Princeton. While not completely convinced of the desirability of replacing one addiction with another, we do think that this enterprise is, so far, bringing in results that do look promising. We recommend that the methadone experiment be broadened and supported.

We note that there has been an increase in cases of hepatitis due to the fact that addicts sometimes share the same needles. We do not want physicians to cross-examine everybody, looking for and reporting all cases of hepatitis; nor do we need a campaign to question all hepatitis victims with the implication that each could be an addict. We approve the present rule requiring the reporting of hepatitis to the State Health Department. Whether a report of these cases should be

made to the State Police and/or to the addiction program at Princeton is a decision to be made by the Health Department.

The AMA has a two-day conference on narcotic addiction scheduled for March 15 and 16 which, we trust, will give us material for a supplementary report. We are sending Dr. Granville Jones of our Special Committee as our representative to that conference.

We note that the active persons in the narcotic control programs in New Jersey are often sociologists, psychologists, parole officers, probation officers, state and city policemen, prosecutors, social workers, clergymen, and sheriffs. We deplore the fact that so few physicians seem interested or involved. The withdrawal of interest by physicians has left a vacuum which many other groups have been eager to fill. We commend this problem to the continuing, vigilant, and devoted interest of all doctors of medicine.

Approved (page 405)

Seizures

J. Lloyd Morrow, M.D., Chairman, Passaic
(Reference Committee "G")



The Committee held three meetings, and in attendance also were the Executive Director, his executive assistants, various officers, and the legislative analyst to the Council on Legislation.

Reporting of Epilepsy

The Committee concerned itself primarily with the study of the laws and regulations dealing with the reporting by physicians of convulsive disorders. As the result of its detailed study, the Committee recommended — and the Council on Mental Health and Board of Trustees approved — that the current law governing physicians' reporting of epilepsy as contained in the Revised Statutes 26:5-1 through 26:5-13 be repealed and that substitute legislation be proposed. With the collaboration of a representative from the New Jersey Division of Motor Vehicles, the Committee evolved a draft of legislation entitled "An Act concerning reporting of epilepsy and repealing Sections 26:5-1 through 26:5-13 of the Revised Statutes." This Act would make the reporting by treating physicians of convulsive disorders mandatory only in cases uncontrollable by medical treatment, and would place the responsibility for the reporting of convulsive disorders on the driver applicant so afflicted. Other recommendations for safeguarding the confidentiality of reports and for suitable penalties for violations were included.

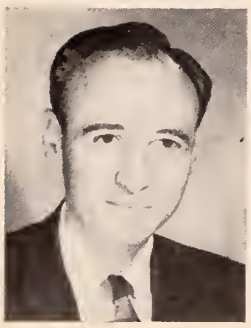
Seizure Disorders

The Committee devoted much effort and study to the definition and delimitation of seizure disorders. Many existing classifications were reviewed and found inadequate for a concise program of education and public information. Efforts are in progress to obtain information about programs concerned with the statewide education of physicians and distribution of materials to the lay public and the news media, with emphasis being place on a bibliography of informational sources.

Approved (page 405)

Emotional Disorders Of Childhood And Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus
(Reference Committee "G")



The Committee held two meetings. A third meeting was cancelled because of poor attendance.

We began our work by communicating with the secretary of each component society, alerting each to the Committee's functions and enlisting his response to a questionnaire assessing the nature of mental health facilities for children and adolescents in his county, especially focusing on existing problems and/or deficiencies. The questionnaire was formulated to stimulate the interest of the officers and membership of each society to deal with problems in the Committee's area of interest. To date, replies have been received from two counties; two other counties' replies are known to be in preparation.

We considered current trends in dealing with reading disabilities (dyslexia), and we reviewed the literature on this subject. We are in the process of soliciting data from ophthalmologists, optometrists, and other professionals working in this field. We are developing a statement on the etiology, pathology, and treatment of this disorder for possible adoption as an official statement by MSNJ, for the information of our members, and possibly members of other professions and the public.

Approved (page 405)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland
(Reference Committee "G")



The Committee decided it could best serve and function if empowered to consult and confer with medical representatives of the Division of Mental Retardation of the Department of Institutions and Agencies, the New Jersey Division of the National Association for Retarded Children, and the State Special Education Services. It was our feeling that by working with the already established areas, we could best introduce the Committee's thoughts and the thoughts of the Council on Mental Health, and thus introduce judicious medical direction in programing and aid materially in establishing medical guidelines for proper care and facilities for the mentally retarded. It was further reasoned that by this approach we, as a society, should begin to exert pressure for the establishment of a complete diagnostic and evaluation center for the mentally retarded, completely separated from state institutional control.

Approved (page 405)

Council on Public Health

John P. Coughlin, M.D., Chairman, Jersey City
(Reference Committee "G")



Once again the work of the Council on Public Health has been greatly expedited by the efforts of the special committees to the Council. Following the report of the Council, will be the report of each of the special committees, giving detailed accounts of their activities.

Preventive Therapy of Tuberculosis

At the initial meeting of the Council, William J. Dougherty, M.D., Director of the Division of Preventable Diseases of the State Department of Health, discussed a program which the Department of Health will conduct on the "preventive therapy of tuberculosis." Doctor Dougherty requested the endorsement of MSNJ in this endeavor especially through publication in *The Journal* of an article or series of articles that the Department of Health would prepare. The Council lacked a quorum. It therefore forwarded the request to the Board of Trustees with the expressed support of the Council members present.

Viral Hepatitis Among Drug Users

The Department of Health, through Doctor Dougherty, informed the Council of the increasing problem of viral hepatitis among drug users, especially in the age group from 15 to 24.

Doctor Dougherty stated that his purpose was to alert The Medical Society of New Jersey and all practicing physicians to the fact that there is a high incidence of viral hepatitis among young male drug users. He urged that: 1) Full reporting of such cases be encouraged; 2) The medical profession exercise positive leadership in this area; 3) Efforts be made to establish a confidential, medically-oriented reporting system to the Department of Institutions and Agencies on a form to be evolved by the Department.

After detailed discussion the Council *recommended* the following to the Board of Trustees:

1) That the entire matter be referred to the Special Committee on Drug Addiction of the Council on Mental Health for study and action.

2) That Doctor Dougherty be invited to prepare an article for submission to *The Journal* to inform the members of MSNJ of the existence and scope of the problem and its related aspects.

The Board of Trustees subsequently approved the recommendations of the Council.

The Incinerator Code

Chapter XI of the New Jersey Air Pollution Control Code was brought to the attention of the Council by the Special Committee on Air Pollution Control. The Council in support of the opinion of the Special Committee submitted the following *recommendations* to the Board of Trustees:

1) That MSNJ support Chapter XI of the New Jersey Air Pollution Control Code (Control and Prohibition of Air Pollution from Incinerators) and request an early effective date.

2) That MSNJ call upon the State Department of Health to seek out alternative methods, freer from pollution effects than incineration and capable of transmitting useless solid waste to useful products.

Approved (page 405)

Sub-Committees of the Council on Public Health

Air Pollution Control

Roslyn Barbash, M.D., Chairman, Teaneck
(Reference Committee "G")



During the past year the Committee concentrated its efforts in the following areas:

Physician Education

A demonstration booth was manned by the Committee at the Annual Meeting last May. It contained reports of component societies' air pollution control projects, exhibits of physicians' research, and delineation of areas where physicians can be effective participants in air pollution control. Educational material was distributed to component societies' air pollution control committees for their information and dissemination on a local level. The first of a series of articles prepared by the Chairman will appear in the April issue of *The Journal.* An article prepared by Commissioner of Health Kandle will be reprinted in *The Journal* in the near future.

Doctor Kandle, pursuant to the request of MSNJ, has agreed to provide an active scientific program on air pollution control at the Society's 1969 Annual Meeting. The program will be conducted by the State Department of Health, with the cooperation of the Committee.

The Chairman of the Committee, subject to the approval of the Board of Trustees, will attend the 5th AMA Congress on Environmental Health, to be held in April in Chicago.

Legislative Developments

A member of the Committee offered testimony at a hearing on the New Jersey Air Pollution Control Code on health hazards caused by sulfur oxides from fuel combustion. Subsequently, the Committee was informed that, because the equipment to be used in removing sulfur from smoke stacks will not be operational for at least four years, the effective date of the Sulfur Code has been delayed. Doctor Kandle has indicated that he will impose the original proposed limitations on coal.

The Committee brought Chapter XI of the Air Pollution Control Code to the attention of the Council on Public Health. The Council, in turn, endorsed Chapter XI, which entails the Control and Prohibition of Air Pollution from Incinerators, and urged the Department of Health to seek alternative methods of waste disposal, freer from pollution effects than incineration and capable of converting solid waste into useful products.

Public Education

The Committee cooperated with the Governor in proclamation ceremonies for "Cleaner Air Week." Members of the Committee have given addresses at schools, service organizations, clubs, and citizens' clean air clubs. They have also participated in radio and television programs, and written articles for newspapers and medical bulletins.

Future Activities

In the upcoming year, the Committee will concentrate its efforts on cooperation with the Division of Clean Air and Water in producing a scientific program for the 1969 Annual Meeting, and follow-up on securing membership on the Governor's Clean Air Advisory Council.

In addition, the Committee will study means for developing centers for the acquisition of clinical data to be used in the promulgation of legislation to curb air pollution. The Com-

mittee shall also study proposed codes by the Department of Health on the control of pollution from fluorides, diesel gasoline combustion engine exhausts, phenols, and nitrogen and chlorine compounds, with the intention of either supporting these codes or suggesting amendments.

Approved (page 406)

Cancer Control

John L. Olpp, M.D., Chairman, Englewood
(Reference Committee "G")



The Committee on Cancer Control has formulated a progressive cancer program, and the chairman commends the members for their interest and zeal.

Survey of Cancer Programs in New Jersey Hospitals

Questionnaires were sent to 88 general hospitals licensed by the State of New Jersey, and *all* were returned. Similar questionnaires were sent to 17 Federal, State, County, and Municipal hospitals in New Jersey, and 14 were returned. The results of the survey follow:

	Licensed General Hospitals	Governmental Hospitals
Hospitals with Tumor Registry and Committee on Cancer	52	7
No Tumor Registry or Committee on Cancer	21	5
Tumor Registry *only*	13	2
Committee on Cancer *only*	2	0

The Tumor Registry at Bergen Pines County Hospital completed its 5th year collecting cases from the hospitals in Bergen County. The registry contained 11,200 cases on March 20, 1968. Follow-up of the cases is disappointing – best rate only 69 per cent – so that the value of the central registry is impaired and its continuation in jeopardy.

The Committee recommended that each hospital designate a contact officer for the Society to deal with in accumulating information concerning hospital cancer control activities.

Cancer Detection Programs

The Northwest Bergen Regional Heath Commission and the American Cancer Society, Bergen County Chapter, put on a uterine cancer education program on November 18, 1967, at the Valley Hospital in Ridgewood. Applications were sent to women residing in Waldwick, Midland Park, Franklin Lakes, and Upper Saddle River. Applications returned numbered 343, and 288 appointments were scheduled for "pap" tests. Due to cancellations or failure to appear, 204 "pap" tests were done. Two cases were deemed "suspicious," and one of these was found to be positive. This is a high yield for a cancer survey.

A breast Cancer Detection Program has been planned for April 24, 1968 by the Bergen County Medical Society, Bergen County Health Department, and Bergen County Chapter of American Cancer Society. Clinics will be held in eight hospitals. On March 30th at least 500 applications for appointments had been received.

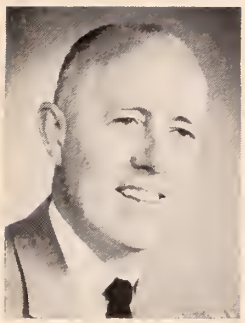
The Committee will submit cancer abstracts, timely articles, and lecture notes on diagnosis and treatment of cancer for publication in *The Journal.*

The members of The Medical Society of New Jersey are urged to diagnose cancer early, and to this end to make every office a cancer detection clinic.

Approved (page 406)

Child Health

William J. Farley, M.D., Chairman, Nutley
(Reference Committee "G")



During the past year the Committee has attempted to concentrate its efforts in the most essential areas of preventive child care. A program of this nature will necessitate long-range planning.

Perinatal Morbidity and Mortality

"A Guide For Hospital Perinatal Mortality Study Conferences" is nearing completion. This Guide is a practical format to encourage study conferences in each hospital in New Jersey. It will permit each hospital to review and evaluate its own experience. The objective of the Guide is physician education. The Committee has solicited the cooperation and assistance of Doctor Preece and his Special Committee on Maternal and Infant Welfare. When the Guide is in the approved form it will be submitted for approval as a joint effort, with the following proposed implementation.

a. Copies of the Guide to be sent to all New Jersey Hospital Administrators and the Chiefs of Obstetrics and Pediatrics.

b. Follow-up through the initiation of county and area "demonstration" study conferences through the component county societies. Such an effort has already been planned in Essex County.

A recommendation for the adoption of this program will be presented to the Council on Public Health.

Child Health Supervision

Preparation of "A Guide For Child Health Supervision" is planned. Material has already been submitted by members of the Committee. It is intended that this Guide be a comprehensive outline for the physician in private or clinic practice. It will include all elements of the total care of the well child at periodic and regular visits from birth through adolescence, namely: evaluation of development and physical growth, diet and nutrition, daily schedule and habit patterns, immunizations, and especially basic principles of parental guidance and emotional health.

This project will utimately recruit the participation of other special committees of The Medical Society of New Jersey. It is particularly important to establish adequate schedules for child health care in the event that a Title XIX Program is enacted in New Jersey.

School Health

Members of the Committee have been active in the development of the New Jersey Association of School Physicians. The objectives of the Association have been to upgrade the "image" and performance of the school physician and to define for the educator, the role and responsibility of the school physician in health education and curriculum planning.

The Second Annual Postgraduate Course for School Physicians will be held on April 10, 17, 24, 1968 at Rutgers University. The program will include pertinent and provocative topics for discussion by outstanding speakers.

The Committee has reviewed the recently completed booklet, "Guidlines For Developing School Programs in Sex Education" published by the New Jersey State Department of Education, and it anticipates further communication with the Department of Education as indicated. Liaison will be maintained in other areas of health education as well.

Doctor McFarland has been in contact with officers of the National Junior Football Federation, to establish rules and guidelines

for participants in Junior League Football. Much work is needed in this entire area of sports activity in New Jersey.

The chairman appointed Doctors McFarland and Castado to conduct further studies on Junior League Football for subsequent report and recommendation to the Committee.

The chairman wishes to express his sincere appreciation to Doctor Collins, Mr. Nevin and Mr. Maressa for their presence and guidance at Committee meetings, as well as to all members of the Committee for their work during the year.

Approved (page 406)

Conservation Of Vision

Frank B. Vanderbeek, M.D., Chairman, Paterson
(Reference Committee "G")



Amblyopia Detection and Screening Program

The recommendation last year of the Conservation of Vision Committee to turn the Amblyopia Detection and Screening Program over to the New Jersey Commission for the Blind was approved by the Trustees of The Medical Society of New Jersey, with the request that no substantial changes in the program be initiated without previous consultation with The Medical Society of New Jersey. Such assurance was given in June 1967 by the New Jersey Commission for the Blind.

Eye Health Screening Program

In September, on behalf of The Medical Society of New Jersey, the Committee conducted — in conjunction with the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Department of Health, the New Jersey Hospital Association, The Woman's Auxiliary to The Medical Society of New Jersey, and the New Jersey Commission for the Blind — the 11th Annual Eye Health Screening Program. The Ophthalmologists of the State staffed 74 centers and one Mobile Unit under the supervision of the New Jersey College of Medicine and Dentistry and the New Jersey Commission for the Blind.

A total of 10,620 individuals were screened — an increase of 3,218 over last year: 5,946 were found to have negative results and 4,674 positive results.

There were 576 tonometry positive results, or 12.32 of the total.

There were 4,012 visual acuity positives, or 85.09 per cent of the total.

There were 387 external inspection positives, or 8.27 per cent of the total.

There were 1,085 ophthalmoscopy positive, or 23.2 per cent of the total.

Not only was there a substantial increase of the total number of individuals screened, but a vast increase of the total number of positive findings made this year as compared with last year.

Although, in the view of some members of the Committee, we still have reached but a small percentage of the state population in this survey, it is abundantly apparent that we have screened and found a very substantial number of people who needed and have been brought under medical care. We firmly believe that the great effort of virtually all participating in the screenings is justified by this accomplishment.

On the 20th of October 1967, our Executive Director, Mr. Richard Nevin, sent to the Committee a comprehensive survey of previous Eye Health Screening Programs. He requested a review of the Program as it had been conducted in the past and suggestions for its implementation in the future — especially urging greater help from the participating centers in analysis of the findings. Administrative problems were also presented to the Committee. The question of the justification of the program in view of the small percentage of the population participating was raised. This memorandum served as the chief topic of discussion in our meeting of November 8th. The matter was explored in detail, and ultimately a subcommittee was appointed to report on the matter at the next meeting.

A letter from Dr. Robert E. Murto was received, resigning from the Committee. The resignation was accepted with regret, and a letter commending him for his long interest and activity on the committee was approved.

A motion to request from the Trustees of The Medical Society of New Jersey authorization to conduct another Eye Health Screening Program in September 1968, subject to recommendations of the subcommittee, was made and subsequently approved by the Trustees.

The subcommittee met on the 31st of January, and submitted its report to the Committee at its meeting on February 8, 1968. In essence, the subcommittee recommended the continuance of the present Eye Health Screening Program with a few administrative changes. The use of pinehole vision testing on a limited basis, for future evaluation, was approved.

Approval of The Medical Society of New Jersey was given to the Mobile Eye Health Screening Program, conducted by the New Jersey College of Medicine, to continue and enhance this program. A request that The Medical Society of New Jersey in support of this project endorse the submission for a grant of application to the Federal Government by the New Jersey College of Medicine and Dentistry was approved.

To this end, the Committee recommended and the Board approved a motion that The Medical Society of New Jersey invite all interested members of The Medical Society of New Jersey to man the Eye Mobile Unit on a one-day voluntary basis. (An honorarium may be forthcoming to meet expenses).

The Committee approved a resolution recommending that: The Medical Society of New Jersey endorse, as a necessity in New Jersey, the establishment of a center for research, diagnosis, and treatment of reading and learning disabilities. (Application for a grant to establish such a center at the Newark Eye and Ear Infirmary is in process.)

Upon approval of the foregoing recommendations by the Board of Trustees, the Committee requested that a letter to this effect be addressed to Dr. Anthony Sellitto at the Newark Eye and Ear Infirmary.

Approved (page 406)

Maternal And Infant Welfare

John D. Preece, M.D., Chairman, Trenton
(Reference Committee "G")



The Committee reconsidered the "Standards For An Obstetrical Department." As a result certain amendments were made and, with the approval of the Board of Trustees, the amended "Standards For An Obstetrical Department" were distributed to New Jersey hospitals.

The main function of the Committee is to record and study materials concerning maternal deaths throughout the state. In certain areas of the state, field physicians have not been dependably serving on a voluntary basis. We therefore recommended, with the approval of the Board of Trustees, that the State Department of Health of New Jersey engage, on a part-time basis, qualified physicians to serve in those areas where component societies have no physician dependably serving on a voluntary basis.

The question arose as to the legality of field physicians' securing copies of pertinent medical records from hospitals in cases of maternal death. Pursuant to disposition of this matter, it was recommended that the State Department of Health be requested to render a legal opinion. We have been subsequently informed by the Department of Health that field physicians legally have access to and may secure copies of pertinent medical records from hospitals concerning maternal deaths.

Since this Committee is charged with studying and classifying maternal deaths throughout the State, it is essential that we have the support of educators and state officials. In order to facilitate our work it was recommended, with the approval of the Board of Trustees, that the Chief Medical Examiner of the State of New Jersey and the Chairmen of the Departments of Obstetrics of the State's medical schools be named consultant to the Special Committee on Maternal and Infant Welfare.

Approved (page 406)

Cigarette: Dubious Companion

As an additional reminder about the health effects of cigarette smoking, the AMA has published "The Cigarette — A Dubious Companion." This brochure points out that "an alarming number of Americans persist in making cigarettes their constant companions," although scientific evidence shows that cigarette smoking is dangerous to health. The booklet describes the effects of each puff of smoke as it enters the breathing passages and air sacs of the lungs and stresses that certain conditions and diseases are believed to be aggravated by cigarette smoking.

Concluding that "cigarettes may seem to be harmless companions because their bad effects are not immediately noticeable," the tip cautions that "suddenly, without warning, a serious problem theatening health and even life may develop."

Copies are available at 15 cents each in lots of five or more sets, write to AMA mail order department.

Council on Public Relations

Harry E. Suter, M.D., Chairman, Penns Grove
(Reference Committee "E")



Some years ago the Council declared that public relations, as an end, is the status of public appreciation and esteem won by an individual or an agency in consequence of the worth of services which have been rendered. The Council likewise declared that public relations, as a means, embraces the performance of all those things that should be done and the avoidance of all those things that should not be done in order to achieve the status of having public appreciation and esteem. It is inescapable that a large part of the Society's activities involve dealing with the public. It likewise seems to follow that the way in which the Society's views are presented is of prime importance. However, just presenting views of organized medicine is wholly insufficient. There must be a constant awareness on the part of all members of individual responsibility for "good" public relations. To this end, your Council met and furthered the aims of the Society this past year as indicated below.

Continuing Projects

At its reorganization meeting, the Council decided to continue all continuing projects and procedures of last year, as follows:

1) Publication and distribution of:

(a) *Junior Health Hints* to schools and public libraries

(b) *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies

(c) *Periodic Newsletter* to cooperating agencies/individuals as circumstances require

2) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business and interests, including:

(a) 1967 eye health screening program

(b) 1968 annual meeting

(c) Child Safety Week

(d) Selected official programs and activities

3) Responsibility for bestowal of the Golden Merit Award

4) Responsibility for the press room at the annual meeting

5) Urge continuance — or establishment — of orientation programs for new members under the sponsorship of component societies

6) Encouragement of continuing statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates

7) Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level

Junior Health Hints

In preparation for reissuance in 1967 of the entire series, an evaluation questionnaire was sent to all *Junior Health Hints* users. Fifty per cent returns were made on the questionnaires, which indicated that approximately 185,291 students are reached in the junior and senior high school grades by 291 teachers. The Council studied the results of the survey — especially the overall comments concerning their use and effectiveness—and were gratified by the excellent response. On the basis of the survey results, which were very commendatory, the Council concluded that the *Junior Health Hints* as compiled and distributed should be continued. As the result of suggestions from teachers, six additional papers will be added to the 1968-69 series.

At the suggestion of some of its members, the Council agreed to undertake as a pilot study the suggestion that *Junior Health Hints* be made available to elementary schools, starting in the fourth grade. Investigation through nurses and teachers in selected schools determined that the *Junior Health*

Hints were too technically advanced for this age group and should be limited to junior and senior high school students. Thus the Council has concluded that this publication should not be distributed for use in any grade below the seventh.

County Orientation Programs

As one of its continuing programs, the Council urged continuance — or establishment — of orientation programs for new members under the sponsorship of component societies. The Council surveyed component societies as to whether or not they conducted orientation programs for new members. The response was so limited that the Council reaffirmed its continuing concern covering this area and sent special letters to presidents of component societies. The Council likewise agreed that new members of MSNJ should be oriented toward the benefit of membership in the State Society. To this end, the Executive Director will draw up a set of "procedures of orientation from MSNJ," which will be sent over the signature of the President to each new member of the Society.

Community Health Week

The Council considered the seemingly inconvenient time for "Community Health Week," sponsored under the auspices of the American Medical Association. Each year the third week in October is set aside for this purpose, and each state is requested to cooperate through its component societies. By formal action, the Council made request of the AMA to change the scheduling of "Community Health Week" from October to the Spring. Subsequently, the Essex County Medical Society adopted a resolution for presentation to this House (see page 374), resolving that "MSNJ urge the American Medical Association to change Community Health Week to a date in March, April, or May." The AMA has already decided to survey state medical associations to determine a consensus of appropriate dates.

Golden Merit Award

The 1967 Golden Merit Award was bestowed upon 40 members of the Society, 28 of whom received the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award, since its inception in 1957, to 496. Thus far this year, 42 candidates have been nominated by 12 component societies for the 1968 Golden Merit Award. Following the ceremonies this year, the recipients and their families will be guests of the Society at an informal reception.

County Society Meetings

The Council discussed at some length the problem of getting representative attendance at county society meetings. It was the Council's opinion that component societies should investigate their current programs and attempt to increase membership participation at meetings by reviewing their agenda and revising procedural outlines so administrative details can be handled by executive committees. It is the Council's opinion, also, that a revision of meeting schedules and/or meeting programs might bring out more members. To this end, the Council recommended that component societies be encouraged to review their meeting programs and activities in an attempt to achieve better attendance.

Members

The Council has noted with regret the resignation of Dr. William E. Ryan of Trenton, because of his engagement in a residency program. Your Chairman has also submitted his resignation, because of the pressure of professional commitments.

Approved with thanks for a job well done. **(page 400)**

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside
(Reference Committee "H")



The Committee on Emergency Medical Care has been alert to the status of the Vietnam War and to the rioting in the large cities — especially with reference to the one that occurred in Newark last year.

The Committee recommended — and the Board of Trustees approved — the following:

1) That the State Department of Defense, Division of Civil Defense, retain control over the First Aid Medical Units (each unit has expendable medical supplies for 500 casualties) pre-positioned throughout the State of New Jersey, and that the Department continue its annual inspection of the units and report its findings to the MSNJ Committee on Emergency Medical Care.

2) After reviewing a medical survey of the casualties that occurred during the Newark riot, the Committee was unanimous in the opinion that the hospitals did not take advantage of facilities available to them in an emergency. The Committee has long contended that in an emergency the personnel involved must be prepared to respond instantly and accurately, according to a plan set in advance, if their assistance is to be of maximum value. When the number of patients in a hospital reaches a level beyond the ordinary capacity, consideration should be given to the inauguration of the hospital's disaster plan and other emergency procedures. Also, concentration of casualties in any one hospital should be avoided.

3) That the Society endorse the Model Ordinance Regulating Ambulance Service and urge that all necessary steps be taken to enact its passage into law in New Jersey as soon as feasible and practicable.

4) That the training program for ambulance attendants include the following subjects: anatomy; physiology; restoration of the airway; control of hemorrhage; dressing of wounds; splinting of fractures; treatment of shock; transportation of the injured — various categories; childbirth; cardiopulmonary resuscitation, and abdominal, chest and external injuries. The Board of Trustees approved the recommendation that the responsibility for training ambulance attendants should be assumed by the component societies in New Jersey.

5) That component societies urge their hospitals to establish some agreement in advance that will, prior to arrival of casualties in a hospital emergency room, give all details concerning the extent and nature of the disaster and the type and number of victims on the way.

6) That MSNJ recommend to the New Jersey Hospital Association that hospitals be encouraged to participate in sponsoring Packaged Disaster Hospitals.

7) Since the Medical Self-Help Training Program has been very successful in New Jersey, that MSNJ encourage county auxiliaries, upon authorization of the component societies, to contact local superintendents of schools or district boards of education to elicit their cooperation in establishing the Medical Self-Help Program on an annual basis wherever it is not already in existence.

The Committee has been made aware, by the AMA Commission on Emergency Medical Services through the National Conference on Community and Emergency Medical Service, that emergency medical service in the country is inadequate and outmoded and is not capable of meeting demands. Ten thousand people are injured each day in the United States. Every fourth American will seek service in an emergency room this year. One of two persons will be hospitalized from auto accidents. The following four items are of interest to the establishment in New Jersey of systematic emergency medical service:

1) The establishment of a Community Emergency Medical Care Council in every county for the purpose of making a study in depth as to emergency medical care in the area and to effect required change as necessary. It should embrace both professional and lay persons and have civic leadership and support.

2) Communications from the point of origin (scene) to the facility that is going to deliver emergency medical service or care (hospital). The communication mechanism should embrace command and control sections to receive information regarding an emergency and to pass it on to alert and activate the facilities.

3) Training should be given to ambulance personnel and to all professional individuals, including medical and para-medical personnel in up-to-date care of the emergency victims. It was also suggested that they receive refresher training every year and be licensed by the State based on model standards that were brought out last spring.

Amended to delete the foregoing sentence: "It was suggested . . ." (page 407)

4) Emergency department of the hospital must be properly organized with everything that is necessary for the delivery of modern emergency medical care.

Approved as amended (page 407)

Supplemental Report

During the past year, the Committee has established a very firm relationship with the Division of Emergency Medical Services of the New Jersey State Department of Health. The Committee was informed that the Department is currently developing a total State plan for two-way communications between ambulances and hospitals. Funds for this are available under the 4.02 program of the Federal Highway Safety Act, and the allotment for the New Jersey Highway Department is $90,000.

In order to develop the State plan, a survey-in-depth of the response capabilities of ambulances in New Jersey will be required. The field work is to be done by the Department of Health. The specific information to be compiled by the survey is as follows:

1. Identification and membership of the rescue squads.

2. The geography of their service areas and inter-squad response and back-up support agreements.

3. Equipment and supplies owned and used.

4. Personnel and training of squad personnel.

5. Funding.

6. Willingness to participate in survey-in-depth through field visits.

The Committee was unanimous in submitting the following recommendations which were subsequently approved by the Board of Trustees:

1) That the program be approved by MSNJ.

2) That MSNJ co-sponsor this inventory with the Division of Emergency Medical Services of the New Jersey State Department of Health.

It should be noted that this will not call for financial or staff involvement on the part of the Society.

Approved (page 407)

Medicine and Religion

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "D")

It has been the policy of the Committee this year to continue its program of encouraging the establishment and active operation of committees on medicine and religion at local levels. As well as having an official committee in each component society, our goal has been and is to crystallize operations within the hospitals of New Jersey, so that functionally the work of the Committee will be carried out at the bedsides of those whose health states offer an opportunity for the cooperative efforts of members of the profession of medicine and members of the clergy.

We have maintained close contact with the AMA's Department of Medicine and Religion. In March, Doctor Mulligan of our Committee attended a day-long AMA-sponsored conference in New York City. He reports that work is going forward to evolve a closely-knit structure of committees on medicine and religion that will be unified in purpose and action, from the national level down to the ultimate local hospital unit.

We shall participate in that work of unification. We shall also continue to press for increased use of the joint approach of medicine and religion in the effort to evolve more effective solutions to the pressing problems of drug addiction, alcoholism, veneral disease, traffic and industrial safety, and general social disorientation and discord.

Approved (page 399)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D.,
Chairman, Vineland
(Reference Committee "D")

In view of the fact that there was no significant legislation dealing with retirement plans nor any startling innovations in the field, the Committee did not meet during the past year.

The chairman notes that since the liberalized Keogh provisions went into effect in January 1968, an increasing number of physicians and component societies have expressed interest in Keogh Plan Programs.

Approved with the following recommendation:
That—in view of the plethora of plans available to physicians and liberalizations of the Keogh Law—the Committee on Retirement Plan for Physicians review these selections and distribute information to the membership of MSNJ (page 399)

Traffic Safety

R. Winfield Betts, M.D.,
Chairman, Medford
(Reference Committee "H")

The Committee has had no formal meetings this year and thus has no formal report to make to the House. The Committee, however, noted with satisfaction that — through the Council on Mental Health — representatives of the New Jersey Division of Motor Vehicles have been cooperating with the Society to bring about acceptable legislation regulating physicians' reporting of epilepsy.

Approved (page 407)

Medical-Surgical Plan of New Jersey

Thomas J. White, M.D., Chairman, Board of Trustees, Newark
(Reference Committee "C")



The year 1967 was, for Medical-Surgical Plan, one which ran the gamut from crisis to relative stability, and from celebration to sorrow.

Beginning the year in grave financial condition, the Plan passed through the always-traumatic experience of a rate hearing, then later enjoyed a period of happy celebration of its 25th Anniversary. Year's end found the Plan in improved fiscal condition, but deeply saddened by the fatal illness of Dr. Nicholas F. Alfano, its beloved President, which was to take him from us on January 4, 1968.

Throughout, however, there was record of significant growth and accomplishment by the Plan. Membership grew to a new high, passing the 2.9 million mark by year's end. New programs were undertaken which provided more diversified coverages and more flexibility in method of payment, enabling the Plan to keep pace with the proliferating demands of the market place for a broader scope of benefits and more complete coverage.

Medical-Surgical Plan entered 1967 in the throes of the worst financial crisis in its history, with reserves depleted almost to the vanishing point. The Plan had filed an application for rate relief with the Commissioner of Department of Banking and Insurance on December 15, 1966, asking a 24.7 per cent average premium increase. Only three prior increases had been sought by the Plan since its founding in 1942, the last one having become effective May 1, 1961.

For the first time in history the Attorney General appointed a "public defender" or rate counsel to cross-examine the Plan's presentation of its case. Following protracted public hearings, the Commissioner authorized a rate increase averaging 12 per cent, effective May 1, 1967.

Inasmuch as the law stipulates that any premium increase granted the Plan does not become effective until the next anniversary date of each individual subscriber, a year is required for the cycle to run its course and register the full beneficial impact. However, a modest gain in reserves had been accomplished by the end of 1967, placing the Plan in a more stable fiscal situation.

In response to mounting pressures from large national account groups, which largely set the pattern for health benefits coverage, the Plan requested approval of The Medical Society of New Jersey to offer a Prevailing Fee program to such groups. This concept, developed nationally by Blue Shield, pays the usual, customary, and reasonable charges of a physician without regard to a fixed fee schedule or subscriber's income, when the charges fall within a range that is acceptable to at least 90 per cent of the physician's colleagues.

The Medical Society's House of Delegates voted its approval at the Annual Meeting in May, and the Plan set in motion the implementation of a Prevailing Fee program for the Steel industry, and UniRoyal Corporation, the first national accounts to demand such coverage.

Tooling-up for this program represented one of the most extensive and complex undertakings in Medical-Surgical Plan history. Nearly 8,000 physicians were surveyed by confidential questionnaire as to their usual charges for the procedures they most commonly performed, as well as a number of other procedures. The data provided by these returns was electron-

ically processed to determine the range of charges, through the 90th percentile, for each procedure. At year's end the Plan was preparing to return to each physician a schedule of his charges with an invitation to participate in Prevailing Fee programs, separate and apart from participation in the Plan's basic programs.

While the initial enrollment under Prevailing Fee does not represent a significant portion of the Plan's membership in numbers, the significance of this "breakthrough" in adopting the Prevailing Fee concept cannot be overestimated. Other large national accounts, as well as government programs, are taking this route in their health benefits programs. The ability to offer such a program — and, hopefully, on an even wider basis than currently — may prove the key to Medical-Surgical Plan's future growth, even its survival, in the rapidly and dramatically changing field of health care protection.

The impact of Medicare on the Plan proved of greater magnitude than anticipated. As hospitalization of the elderly increased under Medicare, hospitalization of the younger population of members showed a decline, presumably due in large part to reduced bed availability. This resulted in a drop of about 3 per cent in total benefits paid, from the preceding year, despite the fact that the volume of claims reached a new high.

Also achieving a new high was the Plan's membership, which increased by over 129,000 to top the 2.9 million mark. Growth continued strong in the national accounts area, which continues to hold the most promising potential for the future.

To accommodate the growing number of new and diversified programs, there was internal growth in the Plan's administration. A total of 47 employees were added during the year. A special Programs Section was created to handle national accounts and government programs such as those for Federal Employees and the Civilian Health and Medical Programs for the Uniformed Services.

The latter program, for which The Medical Society of New Jersey was contractor, with the Plan serving as fiscal administrator, adopted December 1 a "usual and customary basis" of payment, replacing the fixed fee schedule negotiated between The Medical Society of New Jersey and the government. At the same time Medical-Surgical Plan was made contractor for the program, with the approval of the Society.

A painstaking and time-consuming endeavor which had been in progress for many months culminated in the distribution of a new Coverage Code Guide to all physicians in the state. The increasing diversification of the Plan's coverages, principally in the area of national accounts, dictated the need for a comprehensive reference manual to aid physicians and their office assistants in quickly identifying the scope of benefits applicable to any patient. Through use of detailed benefit charts, the guide initially set forth the specifics of more than 60 types of coverage, and more were added subsequently. Hopefully, the guide will help simplify the task of preparing claims accurately, which we in the Plan recognize as one of growing complexity for the profession.

The authorized membership of the Board of Trustees was increased in 1967 from 27 to 30. With the resignation of one lay member late in the year, nominations of three Trustees submitted to The Medical Society of New Jersey represent a careful selection of two eminent physicians and one outstanding business leader.

A highlight of 1967 was the celebration of the Plan's 25th Anniversary. In observing its first quarter-century of service to New Jersey, Medical-Surgical Plan honored its founders, Participating Physicians and subscribers, with fine cooperation from County Medical Societies. The observances, which are detailed in another portion of this Report, helped to strengthen the ties between the Plan and its Participating Physicians, cement relationships with County Medical Societies, and remind the public of Blue Shield's record of assistance to the New Jersey community.

The events of the past year bring into focus some of the guidelines along which we must chart our future course. We can take pride in the Plan's fine record during its first quarter-century, but we cannot afford to dwell in the glorious past. Whether the free enterprise system of medicine is to survive or gradually disappear, will depend largely on the survival of Blue Shield as the remaining bulwark of the voluntary mechanism. Strengthening this bulwark means even greater flexibility on the part of Blue Shield — not merely to keep pace, but to lead the way in the dynamically changing field of health care, while preserving the voluntary system that is traditional in a free society.

Comparative Balance Sheet December 31, 1967

Assets	*1967*	*1966*
Cash on Hand and in Banks (Working Funds)	$ 294,028	$ 1,316,031
Investments	19,550,882	12,305,413
Accounts Receivable:		
Subscriptions	1,052,176	1,520,295
National Account Program	1,309,465	329,308
Federal Employee Program	700,766	531,528
Other	29,918	15,541
Accrued Interest and Dividends Receivable	210,322	122,547
Total Assets	$23,147,557	$16,140,663

Liabilities				
Claims Outstanding:				
Reported	$2,751,000		$2,311,000	
Unreported	7,356,000		8,466,000	
National Accounts	375,000	$10,482,000	139,000	$10,916,000
Unearned Subscriptions		2,946,981		2,535,915
Accounts Payable—				
Hospital Service Plan		1,949,947		569,901
Miscellaneous		1,085,988		599,517
Reserve For Group Contract Settlements		1,365,680		497,384
Deposits From Other Organizations		573,554		160,359
Total Liabilities		$18,404,150		$15,279,076
Reserves				
Securities Valuation		$ 593,000		$ 370,300
Special Contingent		100,000		100,000
Unassigned		4,050,407		391,387
Total Reserves		$ 4,743,407		$ 861,587
Total Liabilities and Reserves		$23,147,557		$16,140,663

Annual Statistics—1967

TABLE I

Paid 1967	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	448,291	40.8%	$24,591,287	49.2%	$54.86
Medical	415,329	37.8	14,744,776	29.5	35.50
Obstetrical	40,654	3.7	5,847,928	11.7	143.85
Consultations	54,937	5.0	1,099,610	2.2	20.02
Anesthesia	139,542	12.7	3,698,689	7.4	26.51
Total	1,098,753	100.0%	$49,982,290	100.0%	$ 45.49

TABLE II

Distribution of Rider Services and Payment

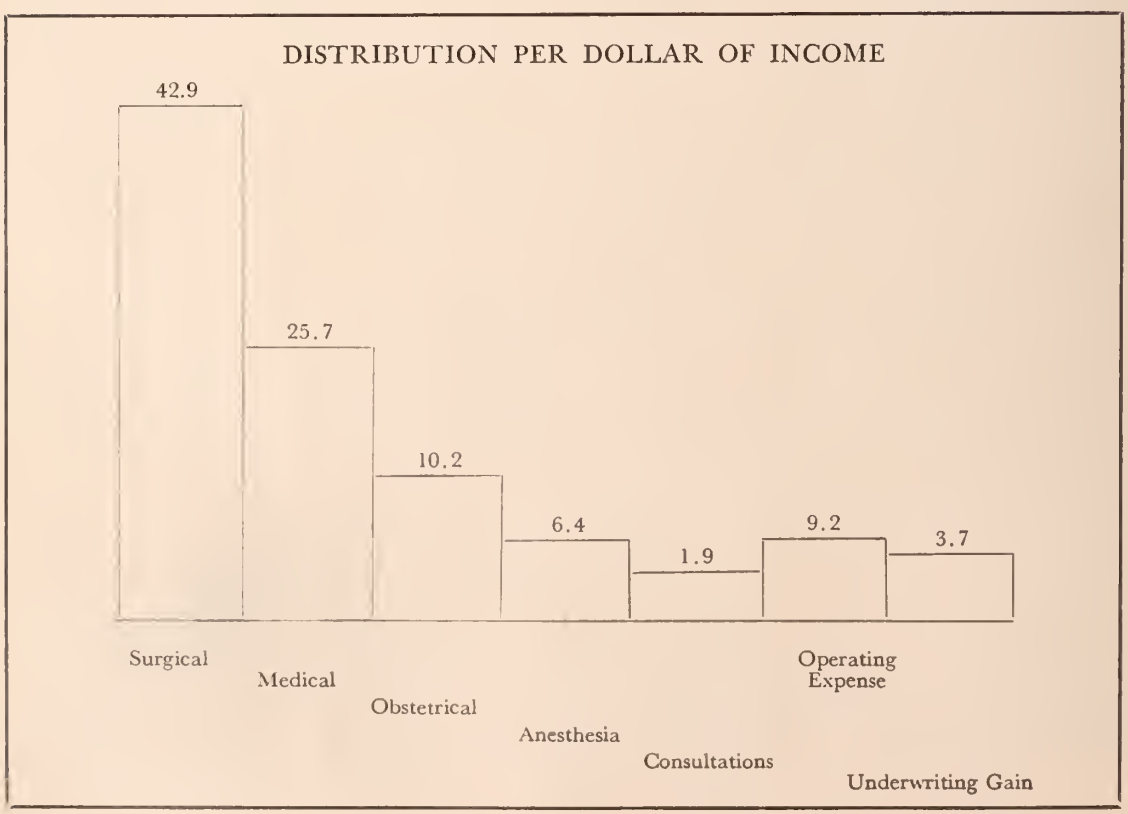
	Total Services	*% All Services*	*Payment Amount*	*Percent*	*Payment Per Service*
Surgical	38,866	16.3%	$ 780,301	16.7%	$20.08
Medical	4,807	2.0	281,996	6.0	58.66
Diagnostic X-ray	94,633	29.7	2,114,025	45.4	22.34
X-ray Therapy	804	0.3	129,423	2.8	160.97
Physical Therapy	7,539	3.2	207,405	4.4	27.51
Pathology	91,991	38.5	1,153,143	24.7	12.54
Total	238,640	100.0%	$4,666,293	100.0%	$19.55

Excludes Federal Claims Data.

TABLE III

Distribution of Earned Subscription Income

Earned Subscription Income	$60,878,649	100.0%
Incurred Claims	53,016,326	87.1
Operating Expense	5,618,439	9.2
Underwriting (Gain)	2,243,884	3.7



Federal Employee Program

Following is a statement of income and expense, along with utilization statistics of the 1967 experience of the Federal Employee Program.

Income	$2,236,946	100.00%
Claims Incurred	2,063,856*	92.26
	173,090	7.74
Operating Expense	119,317	5.33
	$ 53,773	2.41

Paid Basis

Average Exposure (Persons)	117,594
Claim Incidence per 1,000	215
Average Cost Per Case	$79.96
Number of Cases	25,236
Amount Paid	$2,017,856*

*NOTE: Despite their similarity, these figures represent different categories: Claims Incurred include claims for 1967 services that were not paid until after 1967; Amount Paid represents actual disbursements made in 1967, including those for services rendered prior to 1967.

Public Relations Program

From a public relations viewpoint, 1967 stands out as the year of greatest activity and measurable accomplishment since Medical-Surgical Plan undertook its own public relations program in 1961.

Highlight of the year was the celebration of the Plan's 25th Anniversary, with a highly successful program of observances extending over nearly four months. Additionally, the Public Relations Office was deeply involved in the application for a rate increase, with its attendant spotlight of public attention, as well as taking on broadened communications responsibilities in connection with a number of new programs and procedures.

Keynoting the 25th Anniversary celebration was the Plan's expression of appreciation to the Participating Physicians who have made possible its phenomenal 25-year growth, in particular the more than 900 doctors who had served continuously since its first year. Each was awarded a personalized engrossed and illuminated plaque, with most of the presentations being made through the cooperation of County Medical Societies at their meetings.

Also honored with special presentations at an anniversary dinner of the Board of Trustees were the three living founders and the first Participating Physician. Honors also were accorded the Plan's first "three-generation family" of subscribers at a luncheon in which Mrs. Richard J. Hughes, wife of the Governor, graciously participated; management and union representatives of the longest continuously enrolled group were feted at another luncheon. Setting the stage for the observances were proclamations issued by the Mayors of Newark, Trenton and Camden designating "Blue Shield 25th Anniversary Week."

The Anniversary program afforded an excellent opportunity to attract favorable public attention to the Plan's record of growth and progress, as well as clearly establishing its separate identity.

Besides statewide press releases, which appeared in about 150 newspapers, the anniversary was featured in subscriber bill stuffers, physicians' check stuffers, the Blue Cross-Blue Shield publications "Fast Facts" and "Two Blue News," "New Jersey Blue Shield Pulse," "The Blue Shield" of National Association of Blue Shield Plans, the Blue Cross-Blue Shield Community Corner Window, and advertisements in the daily, weekly, and medical press.

Equally important was the public relations involvement in the rate application. Working closely with the Plan's counsel, Public Relations researched much of the material and drafted the presentation for the public hearing; prepared news releases justifying the Plan's need for rate relief; dealt with numerous media inquiries, including taped radio interviews, and prepared releases justifying the Plan's refusal to ask its Participating Physicians to take a voluntary fee reduction, as suggested by the "Public Defender" appointed for the hearing.

The Plan's increasing enrollment of accounts with non-standard coverages, mostly in the national area . . . expansion of responsibilities under governmental programs, such as CHAMPUS . . . undertaking the complexities of a Prevailing Fee Program . . . and the

general proliferation of coverages which required insurance of a comprehensive Coverage Code Guide . . . were among the factors incurring broader communications responsibilities on the part of the Public Relations Office. As the Plan's operations become larger and more complex, its communications become increasingly important, and this area of the Public function will continue to grow more demanding.

Claims Incurred

Year	Amount
1967	$53,016,000
1963	40,991,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

Incidence Rate (Cases) Per 1,000 Persons Enrolled

Year	Incidence
1967	275
1963	193
1960	166
1957	143
1954	126
1961	112
1948	96
1945	86
1942	40

Physician Relations Program

The primary objective of the Physician Relations Section is the maintenance of a "two-way" street of communication between the Plan and its thousands of Participating Doctors. This exchange of information is accomplished by the use of several modes of communication including a field program, telephone calls and correspondence.

During 1967, the Section was forced to restrict its field program and intensify its office activities in order to cope with several new projects, including the Prevailing Fees Program. During the spring and summer, members of the section reviewed and coded thousands of prevailing fee survey returns prior to the keypunch operation. We also handled all telephone calls, and correspondence from physicians questioning facets of this new program. It was gratifying to note the cooperation and interest demonstrated by the majority of the physicians in this dramatic departure from the traditional concepts of pre-paid non-profit health insurance with its fixed fee schedules and income limits.

The Section was also involved to varying degrees, in the preparation and distribution of Coverage Code Guides to every physician and laboratory in the state . . . the distribution of "Silver Anniversary" plaques honoring those doctors who had served as Participating Physicians for twenty-five years . . . the preparation and distribution of Newsletters to the profession advising them of recent changes in Plan policy, procedure, and the Schedule of Payments and conducting training sessions for employees of Blue Shield and Blue Cross, regarding the Prevailing Fee Program.

Even with the sharp curtailment of the field program we still managed to make a number of personal field contacts including addressing physicians at hospital staff meetings, maintaining information desks in the physicians' lounges of hospitals, conducting several meetings of medical assistants, conducting training classes in several schools for medical assistants, and manning Plan exhibits at several medical conventions. In addition, visits were made to numerous physicians' offices, and meetings of specialty societies and county medical societies were also attended.

In the future, with the acquisition and training of additional Physician Relations Representatives, we anticipate an increase in the scope and activities of the field program.

Civilian Health and Medical Program of the Uniformed Services

For the first 11 months of 1967, the Plan continued to act as fiscal administrator of CHAMPUS, on behalf of The Medical Society of New Jersey as contractor. Effective December 1, 1967, the Plan, with the approval of the Society, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Statistical Data

Following is the claim experience for 1967.

CLAIMS

Period	*Received*	*Declined*	*Returned Incomplete*
Total Claims 1967	16,739	66	8,130

Paid

Claims	*Amount*	*On Hand*
8,130	$580,376	625

City of Newark Medical Plan

Effective June 1, 1967, Medical-Surgical Plan of New Jersey assumed the administrative functions of the City of Newark Medical Plan on behalf of Medical Service Administration of New Jersey.

Approved services rendered from January 1, to December 31, 1967, as compared with former years were:

RELIEF

Year	*Number of Cases*	*Value of Services*
1960	1654	$7,417
1961	1484	$6,914
1962	1151	$5,329
1963	1149	$5,339
1964	1164	$5,736.50
1965	1128	$6,287.50
1966	682	$3,770
1967	831	$4,670

MEDICALLY INDIGENT

Year	*Number of Cases*	*Value of Services*
1960	2553	$11,979
1961	1732	$ 8,197
1962	1252	$ 5,999
1963	1189	$ 5,587
1964	862	$ 4,420
1965	962	$ 5,395
1966	931	$ 5,395
1967	482	$ 2,707.50

Enrollment Report

The total membership of Medical-Surgical Plan in 1967 increased 4.7 per cent. This represents a net gain of 129,702 persons covered under 60,996 contracts. Total membership at year-end thus stood at 2,908,799 persons. Nationwide statistics for the first half of 1967 show the Plan has strengthened its fifth rank position among the largest Blue Shield Plans. It is noteworthy that 1967 produced healthy gains in all major lines of business; i.e. Group, Left-Group, Non-Group and Complementary coverages.

Group business accounts for more than 82 per cent of total membership. The 2,392,178 persons so covered can be divided into four major classes; Basic coverage both with and without riders, Government lines, National Account coverages, and Medicare oriented certificates. The Basic certificate is held by 71 per cent of Group members — a drop of one per cent from the 1966 level. The governmental coverages now account for 11 per cent of total Group, reflecting a thirty thousand member increase. National Accounts have shown the largest growth — to a 14 per cent share — via a net gain of 93,133 members. After its initial boom, Complementary coverage added only 2,200 net members to hold a 4 per cent share of the Group line. The trend to more inclusive and tailored benefits is still very much evident. It is indicated by the quarter million persons who added Rider J to their Basic certificate last year, as well as the growth of National Accounts.

The Direct Payment Membership areas were also advanced in 1967. Membership transferred from former Group coverage was up by 9,222 persons. Newly enrolled membership gained 11,962 net persons with about one-third being Student contract holders. A net addition of 4,192 subscribers was recorded in the BC-BS "65" program. Enrollment for the three sub-categories stood at: Left-Group, 197,550 members; Non-Group, 204,097; and BC-BS "65," 114,974. This represents an overall increase of 5.2 per cent in the Direct Payment line over the year-end 1966 level.

From the standpoint of the market, the most significant development in 1967 was the introduction of the Prevailing Fee Program for National Accounts. The Plan's Steel Accounts and UniRoyal are now enrolled on this basis and interest of additional accounts, both national and local is being noted in group contacts by the Sales staff.

Enrollment Growth

Year	Enrollment
1967	2,908,799
1963	2,450,855
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

COMPARATIVE SUMMARY OF OPERATIONS

	1967			*1966*	
Subscriptions Earned*	$60,878,649	100.0%		$56,029,816	100.0%
Less:					
Claims Incurred**	$53,016,326	87.1	$53,523,540		95.5
Operating Expenses***	5,618,439	9.2	4,852,929		8.7
	58,634,765	96.3%		58,376,469	104.2%
Gain or (Loss) from Underwriting Operations	$ 2,243,884	3.7%		(2,346,653)	(4.2%)
Income on Investments	695,095			334,870	
Operating Gain or (Loss) for the Year	$ 2,938,979			($2,011,783)	

* The gain of $4,848,833 in subscriptions earned reflects gains in enrollment, which increased by 129,702 during the year and the 12% rate increase effective 5/1/67.

** The decrease of $507,214 in claims incurred is attributable to the lower cost per claim under the complementary coverage contract, increased exposure from larger enrollment, and to increased incidence, which rose from 266 per 1,000 persons to 275.

*** The increase of $765,510 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $509,214 and an increase of $256,296 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by five tenths of one percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

		1967		*1966*
Reserves at January 1		$ 861,587		$3,653,618
Operating Gain or (Loss) for the Year		2,938,779		(2,011,783)
		$3,800,366		$1,641,835
Plus: Reserve Adjustments				
Non-Admitted Assets	($164,393)	($ 164,393)	($247,194)	
Unrealized Capital Gains	209,464		(210,484)	
Claim Reserve	1,450,000		—	
Distribution of Prior Year's Income	(354,513)		174,814	
Group Contract Settlement	(197,717)	942,841	(497,384)	(780,248)
		$4,743,407		$ 861,587

The increase of $3,881, 620 in reserves for the protection of Plan Subscribers is due to a net operating gain of $2,938,779 and reserve adjustments totaling $942,841.

OFFICERS

Thomas J. White, M.D.
Chairman of the Board

*Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vive President

William S. Skelley
Secretary-Treasurer

1967 BOARD OF TRUSTEES

Chairman of the Board
Thomas J. White, M.D., (1968)

First Vice President

Jerome G. Kaufman, M.D. (1970)
Edwin H. Albano, M.D. (1968)
Robert G. Boyd (1969)
Louis K. Collins, M.D. (1968)
Joseph A. Cox, M.D. (1969)
Charles L. Cunniff, M.D. (1969)
Andrew P. Dedick, Jr., M.D. (1969)
Joseph P. Donnelly, M.D. (1970)
Edgar P. Eaton, Jr. (1970)
Joseph I. Echikson, M.D. (1970)
Lloyd M. Felmly (1968)
Edwin T. Ferren, D.O. (1970)
†Paul M. Forbes (1969)

Second Vice President

Rudolph C. Schretzmann, M.D. (1968)
Mortimer J. Fox, Jr. (1970)
Joseph P. Keating, M.D. (1970)
Elton W. Lance, M.D. (1970)
Samuel J. Lloyd, M.D. (1968)
Theron L. Marsh (1968)
Jesse McCall, M.D. (1968)
Earl R. Mellen (1968)
Donald M. Rosenberger (1968)
Warren H. Simmons (1969)
Sidney I. Simon, Ph.D. (1969)
Charles O. Tyler, M.D. (1968)
Robert E. Verdon, M.D. (1969)

TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Edward W. Sprague, M.D.	1966	1942–1966
John S. Thompson	1966	1942–1965

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
*Harry N. Comando, M.D.	1959	1942–1958
William F. Costello, M.D.	1958	1948–1958
William E. Dodd, M.D.	1952	1944–1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.
1945–1945
* Charles W. Barkhorn, M.D.
1952–1965
Irving P. Borsher, M.D.
1950–1965
* F. Clyde Bowers, M.D.
1961–1963
* Theophilus H. Boysen, M.D.
1944–1945
Lewis W. Brown, M.D.
1949–1954
* William J. Carrington, M.D.
1942–1943
* Samuel A. Cosgrove, M.D.
1944–1953
William K. Harryman, M.D.
1944–1945
Sigurd W. Johnsen, M.D.
1942–1948
* Augustus S. Knight, M.D.
1942–1948
* Thomas K. Lewis, M.D.
1942–1949
* Arthur W. Lunn
1951–1962
Paul Mecray, Jr., M.D.
1953–1961
Daniel E. Minard, Jr.
1957–1965
Glennis S. Rickert, M.D.
1959–1963
* Royal A. Schaaf, M.D.
1942–1964
* Norman M. Scott, M.D.
1942–1950
Reuben L. Sharp, M.D.
1950–1952
James J. Spencer. M.D.
1057–1961
Gustave E. Wiedenmayer
1961–1966
* Carl K. Withers
1952–1961
David L. Yunich
1962–1963

* Deceased
† Resigned

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

	County	Total Eligible Phys.	Participating Total	Participating M.D.	Participating D.O.	Participating D.S.C.	Participating Lab.	Participating D.D.S.	Non-Participating Total	Non-Participating M.D.	Non-Participating D.O.	Non-Participating D.S.C.	Non-Participating Lab.	Non-Participating D.D.S.	% P. P. as of 12-31-67	% P. P. as of 12-31-66
1.	Atlantic	233	211	170	15	14	7	5	22	20				2	90.5	91.5
2.	Bergen	1136	645	512	58	32	15	28	491	443	15	3	1	29	56.7	59.0
3.	Burlington	226	198	145	32	9	2	10	28	24	3			1	87.6	88.6
4.	Camden	645	560	355	146	31	7	21	85	76	4	2		3	86.9	86.9
5.	Cape May	71	64	47	9	4	2	2	7	4	3				90.1	94.2
6.	Cumberland	127	120	100	6	6	4	4	7	4	1			2	94.4	94.4
7.	Essex	1708	1357	1209	43	64	16	25	351	299	9	3	4	36	79.4	79.5
8.	Gloucester	144	124	76	28	9	3	8	20	17	2			1	86.1	87.0
9.	Hudson	713	581	510	12	33	6	20	132	121		2	1	8	81.4	81.7
10.	Hunterdon	65	59	58				1	6	5				1	90.7	93.7
11.	Mercer	501	400	358	14	15	6	7	101	88	4			9	79.8	80.3
12.	Middlesex	478	360	316	14	14	9	7	118	99	1	2	2	14	75.3	76.2
13.	Monmouth	490	345	294	17	15	4	15	145	128	4	1		12	70.4	72.2
14.	Morris	448	356	301	24	8	8	15	92	73	2	2	1	14	79.4	79.8
15.	Ocean	159	108	90	12	3	1	2	51	46	1			4	67.9	71.1
16.	Passaic	655	467	393	25	30	5	14	188	164	3	2	1	18	71.2	72.0
17.	Salem	54	50	39	5	2	1	3	4	3	1				92.5	94.6
18.	Somerset	163	125	114	4	2	1	4	38	31	1	1	1	4	76.6	78.1
19.	Sussex	58	53	41	4	1	1	6	5	5					91.3	91.0
20.	Union	805	538	435	43	36	7	17	267	240	6	2	1	18	66.8	70.0
21.	Warren	50	48	45	1		2		2	2					96.0	95.9
22.	Out of State	290	257	223	28	4	1	1	33	33					88.6	89.8
	TOTALS	9219	7026	5831	540	332	108	215	2193	1925	60	20	12	176	76.2	77.4

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY SPECIALTY

January 10, 1968

	Specialty	Total Eligible Phys.	Participating Total	Participating M.D.	Participating D.O.	Participating D.S.C.	Participating Lab.	Participating D.D.S.	Non-Participating Total	Non-Participating M.D.	Non-Participating D.O.	Non-Participating D.S.C.	Non-Participating Lab.	Non-Participating D.D.S.	% P. P. as of 12-31-67	% P. P. as of 12-31-66
1.	Anes.	371	178	165	13				193	189	4				47.9	51.3
2.	Derm.-Syph.	149	111	111					38	38					74.4	78.2
3.	Int. Med.	1209	917	893	24				292	291	1				75.8	75.9
4.	Neur. Surg.	53	21	21					32	32					39.6	38.3
5.	Obst.-Gyn.	663	352	345	7				311	309	2				53.0	50.9
6.	Ophth.	275	172	171	1				103	103					62.5	64.4
7.	Orth. Surg.	248	152	147	5				96	96					61.2	60.9
8.	Otol.	179	113	108	5				66	65	1				63.1	63.0
9.	Path.	149	123	120	3				26	25	1				82.5	81.3
10.	Ped.	476	426	423	3				50	50					89.4	90.3
11.	Phys. Med.	19	15	15					4	4					78.9	71.4
12.	Plast. Surg.	30	9	8	1				21	21					30.0	29.6
13.	Analy. Labs.	120	108				108		12				12		90.0	89.3
14.	Proct.	37	23	17	6				14	14					62.1	62.5
15.	Psy. & Neuro.	340	246	244	2				94	94					72.3	70.6
16.	Radiology	222	159	153	6				63	63					71.6	74.6
17.	Surg.	813	604	586	18				209	206	3				74.2	73.8
18.	Thor. Surg.	27	17	17					10	10					62.9	57.8
19.	Urol.	173	92	90	2				81	81					53.1	59.1
20.	Chiropody	352	332			332			20			20			94.3	94.3
21.	General	2923	2641	2197	444				282	234	48				90.3	90.2
22.	Dentists	391	215					215	176					176	54.9	57.4
	TOTALS	9219	7026	5831	540	332	108	215	2193	1925	60	20	12	176	76.2	77.4

Approved with thanks to the Plan for its work in behalf of MSNJ. (page 397)

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1968 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

William O. Harris, Atlantic City; Age 60

Bergen County

Lorenz C. Nicol, Bogota; Age 70
Edward T. Seymour, Mantoloking; Age 69
Harrison B. Wilson, Sarasota, Fla. (formerly Hackensack); Age 77

Camden County

Oram R. Kline, Woodbury Heights; Age 76
Ralph S. Wright, Boca Raton, Fla. (formerly Camden); Age 69

Essex County

Louis Byck, Newark; Age 68
William Campbell, Cape Neddick, Maine (formerly East Orange); Age 68
Melvin A. Greer, Bloomfield; Age 58
George A. Paul, Irvington; Age 63
Irving Willner, Maplewood; Age 73
Isidore Zweigel, Newark; Age 69

Gloucester County

Clarence A. Bowersox, Woodbury; Age 64

Hudson County

Francis A. Barone, Jersey City; Age 67
Albert B. Rosenberg, Plainfield; Age 69

Morris County

David F. R. Steuart, Long Island, N. Y. (formerly Morristown); Age 67

Ocean County

William E. Dodd, Beach Haven; Age 75

Passaic County

Samuel C. Yachnin, St. Thomas, Virgin Is. (formerly Passaic); Age 63

Somerset County

Arthur Hochheimer, Bound Brook; Age 84
Abram Levy, Bound Brook; Age 75
Runkle F. Hegeman, Somerville; Age 82

Amended to delete the name of Abram Levy (at his request) (page 407)

Union County

Harry Bloch, Elizabeth; Age 73

Approved as amended (page 407)

Supplemental Report

The following additional nominations for election to emeritus membership have been received:

Camden County

Arthur Gomersall Pratt, Haddonfield: Age 69

Union County

George Ladas, Roselle: Age 66
J. Gerald Pearson, Elizabeth: Age 66

Approved (page 407)

RESOLUTIONS

The following resolutions of appreciation — adopted by the Board of Trustees at its meeting on May 17, 1968 — were received by the House at its opening session, without reference to a committee.

Robert Maddock Backes

Whereas, for ten years Robert Maddock Backes, Esquire, has served loyally and efficiently as legal counsel to The Medical Society of New Jersey; and

Whereas, because of the increasing pressure of his professional obligations, he finds it no longer possible to continue in that capacity; and

Whereas, the Society must defer to his decision, however reluctantly; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey expresses profound appreciation to Mr. Backes for his counsel and guidance so generously and conscientiously given; and be it further

RESOLVED, that the Board extends to Mr. Backes assurance of the continuing gratefulness and esteem of the officers and members of The Medical Society of New Jersey for his fine work in their behalf.

Theresa Elizabeth Goeke

Whereas, for seventeen crowded years Miss Theresa Elizabeth Goeke has efficiently, affectionately, and energetically identified herself with, and endeared herself to, The Medical Society of New Jersey as a member of its staff; and

Whereas, in that time she has advanced from grade to grade in staff-status in simple recognition of her increasing abilities and worth; and

Whereas, in her many endeavors she has given generously of herself that the Society might be progressively benefited; and

Whereas, in consequence she has earned and holds a warm place in the esteem of officers and members alike; and

Whereas, she has now decided to sever the relationship so long established and so well maintained; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey expresses its gratefulness to Miss Goeke for her many years of splendid service and extends to her heartfelt wishes for continuing success, health, and happiness.

#1

Joint Commission on Accreditation of Hospitals

From the Bergen County Medical Society
(Reference Committe "F")

Whereas, the maintenance of highest quality medical care for the American public is the primary concern of every physician in this country; and

Whereas, American medicine is to a major degree hospital oriented and thereby inextricably affected by hospital policy; and

Whereas, the course of professional medical practice is being molded by the trend of third parties to deal directly with hospitals; and

Whereas, major policies are being promulgated by hospital governing boards; and

Whereas, it is eminently obvious that quality medical care is dependent upon a wholesome relationship between the administrative and the professional staff; now therefore be it

RESOLVED, that the Joint Commission on Accreditation of Hospitals include in its basic accreditation criteria a provision that at least one-third of the members of that hospital governing body concerned with the formulation of policies, rules, and regulations be physicians in active practice in the area; and be it further

RESOLVED, that this resolution be forwarded to The Medical Society of New Jersey for whatever action shall be deemed most effective to bring this resolution or its intent to the American Medical Association for implementation.

The following substitute resolution was adopted for Resolutions #1, #13, and #16:

Whereas, increasingly hospitals are becoming centers of medical care and are becoming more and more involved with the practice of medicine; and
Whereas, the governing bodies of said hospitals are comprised of members of the community who are interested in and dedicated to community health; and
Whereas, members of the medical staffs of said hospitals, by virtue of their profession, are interested in and dedicated to the health of the community; and
Whereas, physicians possess unique knowledge of patients and patient-care which would be of inestimable value to hospital boards of trustees in furtherance of the public interest; and
Whereas, in June 1966 the House of Delegates of the American Medical Association declared it to be the policy of the American Medical Association that hospital governing boards be urged to include physicians in their membership; now therefore be it
RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to introduce an appropriate resolution in the AMA House of Delegates urging the Joint Commission on Accreditation of Hospitals to include in its basic accreditation criteria a provision that each hospital be required to include a substantial number of physicians in active private practice on its governing body.

Adopted as amended by the House (page 404)

#2

Employment of Full-Time Professional Legislative Representative

From the Essex County Medical Society
(Reference Committee "A")

Whereas, The Medical Society of New Jersey has for many years employed a legislative analyst to keep its members informed as to pending legislation, which service has been inadequate and ineffective; and

Whereas, frequent problems have arisen in reference to legislation in the State directly affecting the public and the physicians and medical practice without effective or desired political action having been taken by the

Society and its members; and

Whereas, there is a great lack of communication between the physicians of the State of New Jersey and their elected officials, assemblymen, and senators; and

Whereas, the physicians of the State of New Jersey, having been trained in the science of the care of the sick, are best able to advise our legislators on the medical care of the public; now therefore be it

RESOLVED, that the officers and the Board of Trustees of The Medical Society of New Jersey, in the interest of the welfare of all the people of New Jersey, completely reorganize its entire legislative program and retain, on an annual basis, a full-time professional legislative representative whose duties will be to communicate with our elected officials and legislators and advise the various component county societies how to coordinate further effective action; and be it further

RESOLVED, that the officers and Board of Trustees of The Medical Society of New Jersey be directed to support such a professional legislative representative with an adequate staff to implement this directive; and be it further

RESOLVED, that this resolution be communicated to the component county medical societies of New Jersey, and be submitted to the 1968 House of Delegates of The Medical Society of New Jersey for action and implementation.

The following substitute resolution wos adopted for Resolutions #2, #22, #24, #34:

Whereas, the increasing involvement of government in the health care fields and the expanding importance of health care services of all kinds put greater demands upon the Society in projecting and protecting its views ond purposes with reference to the public welfare; and
Whereos, in consequence a review and reorganization of the Society's legislative educational activities are recognized as immediately desiroble; now therefore be it
RESOLVED, that the Council on Legislation, with the approval of the Board of Trustees, proceed to a tightening up of the legislative keyman process and any other aspects of the legislative educational operation that can be improved; and be it further
RESOLVED, that, as indicated and necessary, the Council on Legislation, with the approval of the Board of Trustees, designate and use the services of a selected member or members of MSNJ or any other legislative assistant as official legislative liaison agents of the Society.

Adopted as amended by the House (poge 395)

The Drug-Dependent Patient

The 14th Annual Conference of Mental Health Representatives of State Medical Societies, held in March in Chicago, featured the unveling of a newly created medical exhibit — *The Drug-Dependent Patient.*

The idea for the exhibit originated with the AMA's Department of Mental Health and later was developed more extensively by the Council on Mental Health in cooperation with the Exhibits Section. Various diagnoses and treatment relative to the use of narcotics, sedatives, stimulants, and hallucinogens by drug-dependent individuals, highlight the illustrated display.

The 10-foot exhibit, designed primarily for loan to state and county medical societies, was also presented at the AMA Annual Convention in San Francisco this June. It will be available for booking, but two months' advance notice is necessary to allow time for appropriate arrangements. It is provided on a complimentary basis (except for round-trip freight charges involved in shipping) but is limited to a two-week showing.

Pertinent booking details may be obtained from the Exhibits Section, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

#3

Revision of FAA Medical Examination Form for Pilot Certification

From the Essex County Medical Society

(Reference Commttee "H")

Whereas, at present the Federal Aviation medical examining form does not require applicants for a pilot license to name all physicians who have examined or treated them and to sign a release authorizing such physicians to supply pertinent information from medical records to the Aviation Medical Examiner or other FAA physicians before certification or recertification of the pilot license; and

Whereas, restrictive legislation in this field might be unwise; and

Whereas, public safety in this area of medicine is a factor which must be considered along with the physician-patient relationship; and

Whereas, the Judicial Council of the American Medical Association suggested that the FAA medical examining form be revised to include the specified requirement; now therefore be it

RESOLVED, that The Medical Society of New Jersey officially go on record as recommending and approving such revision of the FAA medical certification and recertification form; and be it further

RESOLVED, that, having so recorded itself, The Medical Society of New Jersey write directly to the FAA urging the change herein described.

Adopted (page 407)

#4

Regulation of Hypnosis for Medical Purposes

From the Essex County Medical Society

(Reference Committee "E")

Whereas, there is presently in New Jersey no legal requirement in any way pertinent to the training or registering of hypnotists who use hypnosis for medical treatment; and

Whereas, local hypnotists claim to relieve or alleviate clinical patient symptoms and sometimes cure bad or unwanted habits; and

Whereas, this treatment in unqualified hands may be to the detriment of the patient; and

Whereas, past legislative attempts and corrective laws became involved with entertainment hypnosis which should not concern us; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively seek legislation encompassing the following points:

(1) Hypnosis, practiced for the purpose of alleviating clinical symptoms as in a doctor-patient relationship, should be exercised by a physician or dentist licensed by the proper Board of Examiners of the State of New Jersey or a licensed clinical psychologist.

(2) The hypnotist should be certified by a New Jersey registry as an ethical and qualified person in the art of hypnotism for medical purposes.

Not approved (page 400)

#5

Community Health Week in the Spring

From the Essex County Medical Society

(Reference Committee "E")

Whereas, the American Medical Association annually requests medical societies to participate in a "Community Health Week" the third week of October; and

Whereas, this calls for months of planning at the state and local levels to do the job well; and

Whereas, medical society committees are relatively inactive during the Summer vacation months and unable to devote the necessary time to prepare for this week held in October; and

Whereas, the AMA has offered to print seven-color billboard posters for display on local sign boards with local medical society imprint during the October Community Health Week; and

Whereas, inquiry discloses that most local sign companies are unable to give free space for these signs at that time because the billboards are all taken with new car ads and political slogans; and

Whereas, medical society committees could adequately prepare for a Community Health Week if it were held in the Spring; and

Whereas, free billboard and advertising space is more available in the Spring; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the American Medical Association to change Community Health Week to a date in March, April, or May.

Approved (page 400)

#6

Hospital Chaplaincy Programs

From the Essex County Medical Society

(Reference Committee "D")

Whereas, rapport between physician and clergy is a necessary part in treating the whole man; and

Whereas, the hospital chaplain should ideally have access to the physician, so information may be exchanged; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to the New Jersey Hospital Association that each hospital in New Jersey support a chaplaincy program by providing space for same and, wherever possible, financial support.

Approved (page 399)

#7

Specialty Services to Welfare Recipients

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the use of diagnostic, laboratory, and medical specialty services found necessary by the treating physician have become an accepted and vital part of good medical care; and

Whereas, some hospital clinics have refused to accept welfare clients at current welfare rates; and

Whereas, welfare recipients are unable to obtain such services from any free source; and

Whereas, county welfare recipients are entitled to comprehensive health care, including all diagnostic tests found necessary by the treating physician; now therefore be it

RESOLVED, that The Medical Society of New Jersey petition the New Jersey State Department of Institutions and Agencies to establish the principle throughout New Jersey that diagnostic, laboratory, and medical specialty services be allowed when found necessary by the treating physician; and be it further

RESOLVED, that the payment for these services be on a realistic, reasonable, and customary fee basis;

and be it further

RESOLVED, that The Medical Society of New Jersey deal directly on the state level with the Department of Institutions and Agencies to embody these principles in their present and future plans, so there will be no mistake of our intent or resolve and so that these tenets be affected by May 1969.

Approved as amended by the House (page 404)

#8

Reasonable and Customary Fees for Welfare Recipients

From the Morris County Medical Society

(Reference Committee "F")

Whereas, there is no reason why anyone working for the government should be paid less than standard fees for services rendered; and

Whereas, it has become an accepted practice for physicians to be paid a reasonable and customary fee-for-services rendered to Medicare patients; and

Whereas, fees paid by Medicare at the rate of 80 per cent of the reasonable and customary physicians fee is a higher amount than is currently paid by the welfare boards in New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey petition the New Jersey State Department of Institutions and Agencies to bring the physicians fees for services paid by all welfare boards in the State up to a realistic level on a reasonable and customary fee basis;

and be it further

RESOLVED, that The Medical Society of New Jersey deal directly on the state level with the Department of Institutions and Agencies to embody these principles in their present and future plans, so there will be no mistake of our intent or resolve and so that these tenets be effected by May 1969.

Approved as amended by the House (page 404)

#9

Health Insurance for Pregnancy

From the Essex County Medical Society

(Reference Committee "G")

Whereas, maternal and fetal morbidity and mortality are highest among unmarried women; and

Whereas, pregnancy is a state involving the health of the mother and/or the fetus; and

Whereas, health insurance in many European countries recognizes pregnancy as a medical condition and makes maternity coverage available to all females regardless of marital status or length of time of marriage; and

Whereas, certain insurance contracts in the name of one company will allow such coverage depending on the place of employment; now therefore be it

RESOLVED, that The Medical Society of New Jersey appoint a committee to meet with members of the Health Insurance Council in an attempt to resolve this problem forthwith.

Foregoing paragraph amended to read:

RESOLVED: that The Medical Society of New Jersey appoint a committee to meet with members of the Health Insurance Council and with representatives of Hospital Service Plan of New Jersey and Medical-Surgical Plan of New Jersey, in an attempt to resolve this problem forthwith.

Approved as amended by the House (page 406)

#10

Health Insurance for Complications of Pregnancy

From the Essex County Medical Society

(Reference Committee "G")

Whereas, the fixed length of time in health insurance coverage does not take into account the complications, such as pyelitis of pregnancy, ante-partum bleeding, toxemia of pregnancy, and hyperemesis, which may arise either pre- or post-natally, and many other identifiable complications; and

Whereas, any required hospitalization past the length of such fixed time unjustly penalizes the patient; now therefore be it

RESOLVED. that The Medical Society of New Jersey petition the Hospital Service Plan of New Jersey to show leadership in correcting this inequity.

Approved (page 406)

#11

Professional Liability Insurance Audit

From the Passaic County Medical Society
(Reference Committee "D")

Whereas, The Medical Society of New Jersey has negotiated in the past with professional liability insurance carriers for the benefit and protection of the members of The Medical Society of New Jersey; and

Whereas, The Medical Society of New Jersey will continue to negotiate with such carriers; and

Whereas, the membership is entitled to be apprised of the cost of professional liability insurance and to be assured of obtaining full value therefrom; now therefore be it

RESOLVED, that The Medical Society of New Jersey employ an independent auditor to review the necessary books and accounts of the carrier *annually* and publish a statement of the audit, to be distributed to the membership.

Not Approved. The reference committee concluded that it was unnecessary, because the matter referred to in the resolution is contained in and dealt with in the annual report of the Committee on Medical Defense and Insurance. (page 399)

#12

Statement on Abortion

From the Morris County Medical Society
(Reference Committee "G")

Whereas, the State of New Jersey has not revised its statutes pertaining to abortion in the recent past; and

Whereas, current sociologic thinking has demonstrated the need for gross revision in said statutes; and

Whereas, the American Medical Association, in its Convention of June 1967, adopted principles that are consistent with current sociologic thought; now therefore be it

RESOLVED, that The Medical Society of New Jersey support the June 1967 resolution of the American Medical Association concerning abortion and actively promote the enactment of legislation to this effect in New Jersey, via the various channels of communication with New Jersey law-making bodies.

Approved (page 406)

#13

Physicians on Hospital Governing Bodies

From the Morris County Medical Society
(Reference Committee "F")

Whereas, voluntary hospitals are a vital and necessary community agency; and

Whereas, the governing bodies of said hospitals are comprised of members of the community who are interested in and dedicated to community health; and

Whereas, members of the medical staffs of said hospitals, by virtue of their profession, are interested in and dedicated to the health of the community; and

Whereas, the members of the medical staffs of these hospitals, in most instances, are prohibited from expressing said interest and dedication in the administrative policies of these hospitals; and

Whereas, this prohibition is discriminatory, arbitrary, and contrary to the best interest of community health; and

Whereas, national accreditation bodies have concurred in this view; now therefore be it

RESOLVED, that The Medical Society of New Jersey take the necessary action to urge and support the appointment of medical staff members to the governing bodies of voluntary hospitals.

The following substitute resolution was adopted for Resolutions #1, #13, #16:

Whereas, increasingly hospitals are becoming centers of medical care and are becoming more and more involved with the practice of medicine; and
Whereas, the governing bodies of said hospitals are comprised of members of the community who are interested in and dedicated to community health; and
Whereas, members of the medical staffs of said hospitals, by virtue of their profession, are interested in and dedicated to the health of the community; and
Whereas, physicians possess unique knowledge of patients and patient-care which would be of inestimable value to hospital boards of trustees in furtherance of the public interest; and
Whereas, in June 1966 the House of Delegates of the American Medical Association declared it to be the policy of the American Medical Association that hospital governing boards be urged to include physicians in their membership; now therefore be it

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to introduce an appropriate resolution in the AMA House of Delegates urging the Joint Commission on Accreditation of Hospitals to include in its basic accreditation criteria a provision that each hospital be required to include a substantial number of physicians in active private practice on its governing body.

Adopted as amended by the House (page 404)

#14

Separate State Department of Mental Health and Mental Retardation

From the Passaic County Medical Society
(Reference Committee "G")

Whereas, mental health and mental retardation are matters of vital concern to both the people and the physicians of New Jersey; and

Whereas, the supervision and delivery of State mental health and mental retardation services have been under the jurisdiction of

the Department of Institutions and Agencies, a non-medically oriented authority, which has proved unsatisfactory; and

Whereas, it is important that all State mental health services, including institutions for treatment of mentally ill and retarded adults and children and for training and research, be unified under responsible and competent medical supervision; and

Whereas, it has been shown in many other states that a medically oriented and directed Department of Mental Health and Mental Retardation is the most efficient and desirable means to achieve favorable treatment of mental illness and mental retardation; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record itself as recommending legislation to establish a separate New Jersey State Department of Mental Health and Mental Retardation, with a physician licensed to practice in New Jersey as Commissioner thereof; and be it further

RESOLVED, that upon introduction of such legislation The Medical Society of New Jersey accord it full and vigorous support.

Not approved. The House rejected the recommendation of the reference committee that this resolution be approved, with revisions. (page 406)

#15

Discontinuance of AID Program

From the Salem County Medical Society

(Reference Committee "C")

Whereas, it is incontrovertible that practicing physicians are faced with an every-increasing load of administrative detail and work as a result of the advent of Medicare and other third parties to the provision of medical care, and that this paper work must inevitably detract from time available for patient care and for the study of medical advances; and

Whereas, the basic proposition that Approval by Individual Diagnosis (AID) has in fact had any influence upon hospital length-of-stay is unsupported, inasmuch as the inauguration and operation of this plan has coincided with other factors, including an increased general awareness of the importance of length-of-stay and the formation of hospital utilization committees which have now become essential for hospital accreditation; and

Whereas, it is agreed by all authorities in the field of hospital utilization study that this is a highly complex matter involving many factors and requiring individualization in judgments and that any simple approach to utilization approval by admission diagnosis only lacks basic merit and is entirely oversimplified; now therefore be it

RESOLVED, that the resolution of the Permanent Committee on Blue Cross and Blue Shield of August 16, 1967, which requires certification by the attending physician on or immediately prior to the date of expiration of AID time allowance, if payment is to be validated, be held as burdensome and unlikely to be productive of result with regard to reduction of hospital length-of-stay, and, further, that the representatives from The Medical Society of New Jersey to the Permanent Committee of Blue Cross and Blue Shield be instructed to seek actively for the rescission of the resolution.

Not adopted. The reference committee agreed with the Board of Trustees that the AID Program is indeed helpful toward better utilization of hospital beds (page 398)

#16

Inclusion of Physicians on Hospital Governing Boards

From the Union County Medical Society

(Reference Committee "F")

Whereas, increasingly hospitals are becoming centers of medical care and are becoming more and more involved with the practice of Medicine; and

Whereas, in New Jersey physicians and representatives of the public serving together are rendering a valuable public service as trustees of the Medical-Surgical Plan of New Jersey, the Health Facilities Planning Council for New Jersey, and various other organizations and agencies; and

Whereas, hospitals must have the service, advice, and cooperation of practicing physicians on their staffs in order to insure satisfactory care for their patients; and

Whereas, physicians possess unique knowledge of patients and patient-care which would be of inestimable value to hospital boards of trustees in furtherance of the public interest; and

Whereas, in June 1966, the House of Delegates of the American Medical Association declared it to be the policy of the American Medical Association "that hospital governing boards be urged to include physicians in their membership; that, also, other appropriate representatives of hospital medical staffs should attend and participate in the meetings of hospital governing boards . . .;" and

Whereas, the National Advisory Commission on Health Manpower has recommended: "To improve the role of physicians in the management of hospitals, we recommend that medical and hospital associations should jointly explore means to increase physician's responsibility for the successful and economical management of hospital operations — and these explorations should consider the including of physicians in the membership of hospital boards of control;" now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey affirm its support of these policies and urge component societies and all member-physicians actively and aggressively to urge the inclusion of a representative number of physicians on the governing boards of all New Jersey hospitals.

The following substitute resolution was adopted for Resolutions #1, #13, #16:

Whereas, increasingly hospitals are becaming centers of medical care and are becaming more and more invalved with the practice af medicine; and

Whereas, the gaverning badies of said haspitals are camprised af members af the cammunity wha are interested in and dedicated to community health; and

Whereas, members af the medical staffs af said haspitals, by virtue af their profession, are interested in and dedicated ta the health af the cammunity; and

Whereas, physicians passess unique knawledge of patients and patient-care which would be af inestimable value ta haspital baards af trustees in furtherance af the public interest; and

Whereas, in June 1966 the House of Delegates of the American Medical Associatian declared it ta be the policy af the American Medical Associatian that hospital governing boards be urged ta include physicians in their membership; now therefore be it

RESOLVED, that The Medical Society of New Jersey instruct its delegates ta the American Medical Assaciatian ta intraduce an appropriate resalutian in the AMA Hause af Delegates urging the Jaint Cammissian an Accreditatian af Haspitals to include in its basic accreditatian criteria a provision that each haspital be required to include a substantial number af physicians in active private practice on its gaverning bady.

Adapted as amended by the House (page 404)

#17

New Method of Medicare Payment

From the Warren County Medical Society
(Reference Committee "F")

Whereas, the Medicare Act was set up to function with the M.D.'s cooperation; and

Whereas, the Medicare Act was set up to pay customary and reasonable fees to the physician in the treatment of Medicare patients; and

Whereas, the medical doctors of Warren County Medical Society have cooperated fully with Medicare and its intermediaries; and

Whereas, Medicare and its intermediaries have failed on their part of the agreement in recently sending checks to the patients in the patient's name upon presentation of a simple physician's bill; and

Whereas, many of these patients have cashed these checks and diverted the funds to other channels, leaving the physician unpaid; now therefore be it

RESOLVED, that the members of the Warren County Medical Society protest most vehemently this new method of payment and request Medicare and its intermediaries henceforth to make out such checks as mentioned in the foregoing paragraph in the names of both the patient and the physician, thus forcing the patient to render the physician his just fee.

Disapproved (page 404)

#18

Assignment of Payment for Medical/Surgical Care

From Gustav L. Ibranyi, M.D., Delegate from Essex County
(Reference Committee "C")

Whereas, the basic concept of health insurance is to pay the providers of health care to meet the medical needs of the patient; and

Whereas, clarification of the mechanisms for payment will improve the doctor-patient relationship; and

Whereas, the assignment method has been found satisfactory to many physicians and patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to all insurance carriers writing health insurance in New Jersey to make available the assignment of payment for medical and surgical care; and be it further

foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey recommend to all commercial insurance carriers writing health insurance in New Jersey to make available the assignment of payment for medical and surgical care; and be it further

RESOLVED, that MSNJ further recommend that space be included for such assignment on insurance forms.

Adopted as amended by the House. The House rejected the recommendation of the reference committee that the resolution be not adopted (page 398)

#19

Determination Of Safety Or Competence Of Automobile Drivers

From Gustav L. Ibranyi, M.D., Delegate from Essex County
(Reference Committee "H")

Whereas, physicians are asked whether or not a patient would be a safe driver on a form for the New Jersey Division of Motor Vehicles; and

Whereas, questions of this nature are for determination by the motor vehicle authorities; now therefore be it

RESOLVED, that The Medical Society of New Jersey take whatever action is indicated to see that physicians be relieved of any obligation to pass on the safety or competence of automobile drivers, this being subject properly to determination by the motor vehicle authorities.

Not approved. The House approved the opinion of the reference committee that the resolution should be returned to the sponsor for better wording and clarification; and, subsequently, that the content of the resolution should be studied by the Society's Committee on Traffic Safety, for deliberation with the New Jersey Division of Motor Vehicles (page 407)

#20

Appointment Of County Legislative Keymen

From Arthur A. Goldfarb, M.D., Delegate from Bergen County
(Reference Committee "A")

Whereas, personal, informed, and coordinated exchange of information between the physician and his elected members of the State Legislature is extremely important in the interest of better health care to the public; and

Foregoing paragraph amended to read:

Whereas, personal, informed, and coordinated exchange of information between the physician and his elected members of the State Legislature is extremely important in protecting health care for the public; and (page 395)

Whereas, in the past "County Legislative Keymen" appointed by The Medical Society of New Jersey were not always the most interested and therefore effective; and

Whereas, this has often resulted in poorly coordinated action and late information to our Legislators; and

Whereas, the County Medical Society is in a better position to know its own members' interest and potential for such action; now therefore be it

RESOLVED, that The Medical Society of New Jersey appoint its "County Legislative Keymen" from a list provided by the President of each component County Medical Society, so that there is one "Legislative Key-

man" for each three state Legislators; and be it further

Foregoing paragraph amended to read:
RESOLVED, that The Medical Society of New Jersey appoint its "County Legislative Keymen" from a list provided by the President of each component county medical society, so that there are adequate Legislative Keymen for each of the state Legislators, and be it further (page 395)

RESOLVED, that, for effective local action, these "County Legislative Keymen" meet at the call of the Chairman of the Council on Legislation of The Medical Society of New Jersey and be provided with such information as regular news letters, telegrams, and specific directives from the appropriate MSNJ official in reference to pending or contemplated legislation; and be it further

RESOLVED, that this resolution be communicated to all other component County Medical Societies and to the 1968 House of Delegates for approval and action.

Adopted as amended by the Reference Committee (page 395)

#21

House Staff Physicians In Community Hospitals

From the Hudson County Medical Society
(Reference Committee "E")

Whereas, there is a dearth of interns and residents available to community hospitals in the State of New Jersey; and

Whereas, it is necessary to have a house staff for good patient care; and

Whereas, it is necessary for community hospitals to hire unlicensed physicians to act as a house staff because of the inability to obtain sufficient licensed physicians to fulfill this function; now therefore be it

RESOLVED, that The Medical Society of New Jersey appeal to the State Board of Medical Examiners to seek legislation to permit community hospitals to hire unlicensed physicians, when necessary, to perform the functions of interns and residents for an aggregate period of no more than two years.

Not approved (page 401)

Allergy Diet Recipe Book

The magazine, *Good Housekeeping*, has now made available a 42-page booklet of recipes for allergy diets. These include such items as blushing-bride pudding, which is egg, gluten and wheat free; chinese almond cookies; and horseradish herb dressing — in all there are over one hundred recipes. The booklet is available for 50¢ from the Good Housekeeping Bulletin Service, 959 Eighth Avenue, New York, New York 10019.

#22

Employment Of Full-Time Professional Legislative Representative

From the Mercer County Medical Society
(Reference Committee "A")

Whereas, for many years the members of The Medical Society of New Jersey have had no single representative in the New Jersey State Legislative Chambers to plead our medical cause; and

Whereas, the Bergen County Medical Society has presented a resolution concerning this, with which the Mercer County Component Medical Society heartily agrees; and

Whereas, in spite of much effort and time expended by various representatives of the Society to support our case, there has been a lack of consistency and continuity due to this variety of persons involved; and

Whereas, this inconsistency would vanish if one person or a group were continually and directly involved with legislation; now therefore be it

RESOLVED, that a professional legislative representative be retained; and be it further

RESOLVED, that this professional legislative representative be directly responsible to the chairman of the Legislative Council and the Board of Trustees; and be it further

RESOLVED, that the chairman of the Legislative Council shall be his mentor, guide, and advisor on all legislative matters; and be it further

RESOLVED, that the duties and responsibilities of this legislative representative shall be delineated and outlined by the chairman of the Legislative Council, who shall be fully cognizant of all the activities of our State Legislature that are related to medicine and the attitude of the medical profession toward pertinent legislation.

The following substitute resolution was adopted for Resolutions #2, #22, #24, #34:

Whereas, the increasing involvement of government in the health care fields and the expanding importance of health care services of all kinds put greater demands upon the Society in projecting and protecting its views and purposes with reference to the public welfare; and
Whereas, in consequence a review and reorganization of the Society's legislative educational activities are recognized as immediately desirable; now therefore be it
RESOLVED, that the Council on Legislation, with the approval of the Board of Trustees, proceed to a tightening up of the legislative keyman process and any other aspects of the legislative educational operation that can be improved; and be it further
RESOLVED, that, as indicated and necessary, the Council on Legislation, with the approval of the Board of Trustees, designate and use the services of a selected member or members of MSNJ or any other legislative assistant as official legislative liaison agents of the Society.

Adopted as amended by the House (page 395)

#23

Conduct Of Meetings Of The Board Of Trustees

From the Atlantic County Medical Society
(Reference Committee "A")

Resolution #23 was withdrawn by the Atlantic County Medical Society.

#24

Engagement Of Legislative Personnel

From the Atlantic County Medical Society
(Reference Committee "A")

Whereas, the practitioners of medicine in the State of New Jersey are subject to the laws of the State of New Jersey; and

Whereas, The Medical Society of New Jersey holds as fundamentally proper the responsibility to represent its constituency through the initiation of legislation in expressing organized medicine's point of view on all other legislation introduced in the New Jersey State Legislature; and

Whereas, The Medical Society of New Jersey holds the responsibility to search out all bills introduced in the two houses of the New Jersey Legislature and to advise its membership either directly or through its county societies of official positions taken on legislation affecting the practice of medicine; now therefore be it

RESOLVED, that The Medical Society of New Jersey employ a full-time, properly registered lobbyist and such legal representatives as might be required during each session of the New Jersey State Legislature to fully represent The Medical Society of New Jersey and its constituency; and be if further

RESOLVED, that it engage without delay such properly registered lobbyist or lobbyists together with appropriate legal counsel for the express purpose of amending the existing Medical Practice Act to insure that its provisions reflect all of the regulations and rules to cover properly all scientific and technicological advances embraced within the practice of medicine and deemed necessary by The Medical Society of New Jersey and its constituency to provide the best possible practice of medicine in the best interests of the health and welfare of all residents of the State of New Jersey.

The following substitute resolution was adapted for Resolutions #2, #22, #24, #34:

Whereas, the increasing involvement of government in the health care fields and the expanding importance of health care services of all kinds put greater demands upon the Society in projecting and protecting its views and purposes with reference to the public welfare; and
Whereas, in consequence a review and reorganization of the Society's legislative educational activities are recognized as immediately desirable; now therefore be it
RESOLVED, that the Council on Legislation, with the appraval af the Baard of Trustees, proceed to a tightening up of the legislative keyman process and any other aspects of the legislative educational operation that can be improved; and be it further
RESOLVED, that, as indicated and necessary, the Council on Legislation, with the appraval af the Baard of Trustees, designate and use the services af a selected member or members af MSNJ ar any other legislative assistant as official legislative liaison agents af the Society.

Adapted as amended by the House (page 395)

The Extended Care Facility

Extended care is the focal point of many discussions today dealing with total patient care. The American Medical Association, rising to meet the need for an assessment of the medical profession's role in the provision, supervision and measurement of such care, has published *The Extended Care Facility*.

This comprehensive, 172-page handbook treats such topics as area-wide planning, patient-care policies, the formation of utilization review committees, models of patient-transfer agreements, and the like. You may buy it from the AMA Order Department, 535 North Dearborn Street, Chicago, 60610. In this country, copies are available for 90 cents each; 70 cents for medical students, interns and residents. Orders should indicate the code number, OP-157, and must include remittance.

#25

Membership On MSNJ Board Of Trustees And State Board Of Medical Examiners

From the Atlantic County Medical Society
(Reference Committee "A")

Whereas, there are instances when members of the Board of Trustees of The Medical Society of New Jersey also serve as members of the New Jersey State Board of Medical Examiners; and

Whereas, the New Jersey State Board of Medical Examiners is required to review violations of the Medical Practice Act and assess all penalties prescribed by this Act; and

Whereas, it is inappropriate and severely difficult for any individual to serve the best interest of two masters, particularly when there are conflicts between such masters; now therefore be it

RESOLVED, that any individual serving on the Board of Trustees of The Medical Society of New Jersey and the New Jersey State Board of Medical Examiners be excused from both discussion and vote of action by the Board of Trustees on any matter pertaining to the Medical Practice Act of the State of New Jersey.

Not adopted (page 395)

#26

Constitutional Amendment To Effect More Proportionate Representation On Board Of Trustees

From Leonard Brown, M.D., Delegate from Bergen County
(Reference Committee on Constitution and Bylaws)

Whereas, it is deemed desirable that the Board of Trustees of The Medical Society of New Jersey provide representation which is proportionate to the number of members in each Judicial District; and

Whereas, the current method of electing Trustees from the five Judicial Districts of the state results in widely disproportionate representation; for example, the Board of Trustees as constituted today has four Trustees representing Districts I and II, with 4470 Active Members, as contrasted with seven Trustees representing 2474 from Districts III, IV, and V; and

Whereas, the Judicial Districts were created almost sixty years ago by a method and for

reasons which nobody today can recall, and which now results in a conglomeration of urban, suburban, and rural counties, with different socio-economic and medical practice problems; and

Whereas, the Board of Trustees should represent doctors and not land mass; and

Whereas, the House of Delegates usually meets for only four days each year, and all active business the remainder of the year is under the executive prerogative of the Board of Trustees; and

Whereas, the following resolution will not increase the size of the Board of Trustees by more than one member more than that recommended by the ad hoc committee amendment to be presented for adopton; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey at its 202nd Annual Meeting amend the constituton as follows:

Constitution

Article VI — Board of Trustees

Current	*Proposed*
The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and *fourteen (14)* members — at least *one (1)* from each judicial district and *one (1) additional trustee for each five hundred (500) additional members or major fraction thereof,* and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.
Any member may be elected a Trustee for a maximum of three (3) full terms.	Same
	The number of Active Members in each Judicial District shall be reviewed every five (5) years for the purpose of maintaining the ratio of one (1) Trustee for every five hundred (500) members or major fraction thereof.
At the first election of Officers following the adoption of this Constitution, *four (4)* members shall be elected for a period of one (1) year; *five (5)* members for a perod of two (2) years; *five (5)* members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three years each.	At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three years each.

Referred to the Society's Standing Committee on Revision of Constitution and Bylaws, for study and report to the 1969 House of Delegates (because Resolution #26 did not conform to the normal constitutional procedure). (page 408)

Coral Snake Antivenin Available

The first U.S. licensed and produced antivenin to combat the potent poison from the North American eastern coral snake has been developed and is now available where coral snakes are found. Wyeth Laboratories has donated, as a public service, enough antivenin (Micrurus fulvius) to treat patients bitten by the eastern coral snake.

To procure the antivenin, notify the nearest poison control center or the State Department of Health in Trenton — or phone 404-633-3311, which is the National Communicable Disease Center in Atlanta, Georgia.

To get advance details of this, you might write now to Wyeth Laboratories, 555 Secaucus Road, Secaucus, New Jersey 07094, or to the Professional Service Department, P.O. Box 8299, Philadelphia, Pennsylvania 19101.

#27

Establishment Of Ad Hoc Committee To Redistrict The State To Provide Proportionate Representation On The Board Of Trustees

From Leonard Brown, M.D., Delegate from Bergen County
(Reference Committee on Constitution and Bylaws)

Whereas, The Medical Society of New Jersey first established its Judicial Districts almost sixty years ago; and

Whereas, today these Judicial Districts are so heterogeneous that they represent neither solely urban, suburban, nor rural areas; and

Whereas, the current allocation of Trustees from these antiquated Councilor Districts results in a widely disproportionate representation of the membership; and

Whereas, actually today more than half of the membership is represented by only four Trustees, and less than half is represented by seven Trustees; and

Whereas, democratic, efficient, equitable standards would indicate a desirability for proportionate representation; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey at its 202nd Annual Meeting direct the Board of Trustees of that Society to establish an ad hoc committee to redistrict the State of New Jersey with the intent of achieving a proportionate representation of the membership on the Board of Trustees; and be it further

RESOLVED, that this ad hoc committee submit its report to the House of Delegates at the 203rd Annual Meting of The Medical Society of New Jersey; and be it further

RESOLVED, that this resolution be forwarded forthwith to the Secretary of The Medical Society of New Jersey in order that it may appear on the agenda of the 202nd Annual Meeting of that Society for consideration and action.

Referred to the Society's Standing Committee on Revision of Constitution and Bylaws, for study and report to the 1969 House of Delegates. **(page 409)**

Ars Medica Center

A museum of art concerning medical material has been established within the Philadelphia Museum of Art, located on the Parkway at Fairmount Avenue in Philadelphia. Known as the Ars Medica Center, this section of the museum will include prints, drawings, photographs, and slides relating to the art and practice of medicine. Material will be readily accessible for reference, study, and loan. It apparently is the only service of its kind.

Originally this was a project of Smith, Kline, and French Laboratories, which in 1948 had only 132 prints. In the past twenty years, the medical museum has grown, and much of its illustrative material has been exhibited on loan in the four corners of the United States, as well as in several foreign countries. For further information, write to Ralph Collier, Public Relations Department, Philadelphia Museum of Art, Philadelphia, Pennsylvania 19101.

#28

Annual Financial Report

From the Bergen County Medical Society
(Reference Committee "B")

Whereas, the Treasurer's annual report is relatively incomprehensible to the average member because:

(a) the invested funds are poorly itemized, in that timing of investments and the interest yield on separate items are not defined; and

(b) the accounts of American Medical Association dues collections are mingled in a confusing manner with state funds; now therefore be it

RESOLVED, that:

(1) the Treasurer's annual report be more complete as to items of investment and the yield from each; and

(2) comingling of items be avoided in every way possible; and be it further

RESOLVED, that this resolution be presented to the House of Delegates of the 202nd Annual Meeting and Convention of The Medical Society of New Jersey for consideration and action.

Approved (page 396)

#29

Amendment To Bylaws Re Fiscal Year

From the Bergen County Medical Society
(Reference Committee on Constitution and Bylaws)

Whereas, the Treasurer's annual report is relatively incomprehensible to the average member because of the fact that it represents only a portion of the fiscal year which at present ends on May 31; and

Whereas, the membership of our Society have never been presented for their approval with a report that included a statement of accuracy and scope of audit. In fact, such is impossible if the fiscal year overlaps or, indeed, is not terminated well in advance of the yearly meeting of the Delegates; now therefore be it

RESOLVED, that MSNJ Bylaws be amended so that the Society's fiscal year coincides with the calendar year; and be if further

RESOLVED, that this resolution be presented to the House of Delegates of the 202nd Annual Meeting and Convention of The Medical Society of New Jersey for consideration and action.

Disapproved with the following recommendation:

That the entire problem be referred to the Society's Standing Committee on Finance and Budget, for further study and report to the 1969 House of Delegates. (page 409)

#30

Discontinuance Of AID Program

From Camden County Medical Society
(Reference Committee "C")

Whereas, the AID Program has required that the physician fill out certification forms for hospitalization beyond the allotted number of days; and

Whereas, the physician is performing the investigative work for their organization; and

Whereas, Blue Cross might still elect not to accept a patient's stay over the allotted time; and

Whereas, the Plan may then not pay for hospitalization beyond the expiration of the number of days unless conditions of certification are met; and

Whereas, the Plan further requires that lacking required certification a letter of explanation be obtained from the physician and filed with New Jersey Blue Cross; and

Whereas, this is tantamount to blackmail of the hospital and the physician; therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey act and vote to advise and instruct all doctors in the state not to fill out these forms and to so inform Blue Cross of this action.

Not adopted. The reference committee agreed with the Board of Trustees that the AID Program is indeed helpful toward better utilization of hospital beds. (page 398)

#31

Standard Insurance Forms

From Camden County Medical Society
(Reference Committee "F")

Whereas, the physician may have three to five or more insurance forms to be filled out for each patient's hospital admission, requiring unnecessary time and expense; and

Whereas, a standard form has been devised to satisfy most of the insurance companies, and copies of this original could be sent to each of these companies; and

Whereas, the American Medical Association recommended and supported such a policy; and

Whereas, renewed recommendation by the American Medical Association Board of Trustees would be helpful in having insurance companies and Medicare adopt standardized forms; therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey approve this resolution and instruct their delegates to the American Medical Association to bring this before the Annual Meeting, June 6, 1968, in the form of a resolution to the House of Delegates of the American Medical Association.

Approved in principle (page 404)

#32

Discontinuance Of AID Program

From Edward G. Bourns, M.D., Delegate from Union County
(Reference Committee "C")

Whereas, the Approval by Individual Diagnosis Program (AID) is experimental and exists only in the State of New Jersey; and

Whereas, this program involves arbitrarily assigning the doctor a certain number of days without taking into consideration numerous other factors besides the basic diagnosis; and

Whereas, this program causes much unnecessary paperwork; therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request the Board of Trustees of The Medical Society of New Jersey to take appropriate action to rescind the resolution which initiated the AID program.

Not adopted. The reference committee agreed with the Board of Trustees that the AID Program is indeed helpful toward better utilization of hospital beds. (page 398)

#33

Membership On MSNJ Board Of Trustees And State Board Of Medical Examiners

From Howard D. Slobodien, M.D., Delegate from Middlesex County
(Reference Committee "A")

Resolution #33 was withdrawn by Howard D. Slobodien, M.D., Delegate from the Middlesex County Medical Society.

#34

Engagement Of Legislative Personnel

From the Middlesex County Medical Society
(Reference Committee "A")

Whereas, the practitioners of medicine in the State of New Jersey are subject to the laws of the State of New Jersey; and

Whereas, The Medical Society of New Jersey holds as a fundamental purpose the responsibility to represent its constituency through the initiation of legislation and in expressing organized medicine's point of view on all other legislation introduced in the New Jersey State Legislature; and

Whereas, The Medical Society of New Jersey holds the responsibility to search out all bills introduced in the two houses of the New Jersey Legislature and to advise its membership either directly or through its county societies of official positions taken on legislation affecting the practice of medicine; therefore be it

RESOLVED, that The Medical Society of New Jersey employ a full-time, properly registered lobbyist and such legal representatives as might be required during each session of the New Jersey Legislature to fully represent The Medical Society of New Jersey and its constituency; and be it further

RESOLVED, that it engage without delay such properly registered lobbyist or lobbyists together with appropriate legal counsel for the express purpose of amending the existing Medical Practice Act to ensure that its provisions reflect all of the regulations and rules to cover properly all scientific and technological advances embraced within the practice of medicine and deemed necessary by The Medical Society of New Jersey and its constituency to provide the best possible practice of medicine in the best interest of the health and welfare of all residents of the State of New Jersey.

The following substitute resolution was adopted for Resolutions #2, #22, #24, #34:

Whereas, the increasing involvement of government in the health care fields and the expanding importance of health care services of all kinds put greater demands upon the Society in projecting and protecting its views and purposes with reference to the public welfare; and

Whereas, in consequence a review and reorganization of the Society's legislative educational activities are recognized as immediately desirable; now therefore be it

RESOLVED, that the Council on Legislation, with the approval of the Board of Trustees, proceed to a tightening up of the legislative keyman process and any other aspects of the legislative educational operation that can be improved; and be it further

RESOLVED, that, as indicated and necessary, the Council on Legislation, with the approval of the Board of Trustees, designate and use the services of a selected member or members of MSNJ or any other legislative assistant as official legislative liaison agents of the Society.

Adopted as amended by the House (page 395)

#35
Osteopathy

From Richard B. Berlin, M.D., Delegate from Bergen County
(Reference Committee "A")

Whereas, osteopathic physicians are granted unlimited licenses to practice in the State of New Jersey; and

Whereas, the essential difference between osteopathy and medicine has been declared by the AMA Board of Trustees to be one of quality; and

Whereas, government funds for health programs and hospital building projects are dispensed to physicians and osteopaths alike; and

Whereas, failure to correct the qualitative differences between osteopathic practice and medical practice will dilute the high standards of medical care and will be against the public interest; and

Whereas, organized osteopathy has shown no interest in uniting with organized medicine; now therefore be it

RESOLVED, that:

(1) The Commissioner of Education of the State of New Jersey is herewith advised that the public interest will best be served if all medical schools in the state henceforth shall prepare students for the degree of doctor of medicine as a minimal basis for licensure to practice medicine and surgery; and

(2) All approved hospitals in New Jersey shall be encouraged to accept on their staffs osteopathic physicians who base their principles of practice on the same scientific basis as members of the AMA; and

(3) Membership eligibility standards for county medical societies should be amended to permit membership of qualified doctors of osteopathy.

Referred to the Society's Standing Committee on Revision of Constitution and Bylaws, because approval of this resolution would be contrary to the Charter and Constitution and Bylaws of MSNJ as they now exist (page 395)

MEMORIAL RESOLUTIONS

The following memorial resolutions were received by the House with sorrowful concurrence, without reference to a committee:

Nicholas F. Alfano, M.D.
1910-1968

Whereas, God in His wisdom has seen fit to summon Nicholas Francis Alfano, M.D., from our midst; and

Whereas, through diligent and loyal services to the Medical-Surgical Plan, culminating in his leadership as its president, Dr. Alfano consistently and equally advanced the interests of both the public and the members of The Medical Society of New Jersey; and

Whereas, by the integrity of his character, his devotion to humanitarian goals, and his endearing personal traits he was a source of encouragement and inspiration to all who knew him; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record profound grief at his untimely passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting.

J. Howard Hornberger, M.D.
1896-1968

Whereas, Almighty God has seen fit to summon from our midst His good servant and our beloved colleague, J. Howard Hornberger, 156th President of The Medical Society of New Jersey; and

Whereas, for almost five decades Dr. Hornberger gave to the practice of medicine his excellent best, manifesting always sage and humanitarian qualities that made him respected and loved as a physician and a man; and

Whereas, his death brought to a close a lifetime of exemplary service to medicine and his fellowmen; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting.

REFERENCE COMMITTEES

Reference Committee "A"

Charles Cunningham, M.D., Chairman

Reference Committee "A" met on Sunday, May 19, 1968, with all members present: Doctors Augustus L. Baker, Jr., William A. Dwyer, Jr., Robert E. Jennings, Francis A. Pflum, and the chairman. Approximately 42 delegates and members were present to discuss the various items under consideration.

1. **President** (page 283)

The committee *recommends* that the report be approved.

Adopted

2. **Board of Trustees** (page 292)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The committee *recommends* that the report be approved.

Adopted

a. **Joint Conference with Presidents of Component Societies** (page 292)

The committee *recommends* that this item be approved.

Adopted

b. **Professional Liability Panel—Supplemental #1** (page 296)

The committee *recommends* that this item be approved.

Adopted

c. **Relief of Widows and Orphans of Medical Men** (page 292)

It was noted that there are now 1,350 members and that the death benefit is at $1,050. The committee *recommends* that this item be approved.

Adopted

3. **Secretary** (page 285)

The committee *recommends* that this item be approved.

Adopted

4. **Judical Council** (page 303)

The committee *recommends* that this item be approved.

Adopted

5. **Executive Director** (page 305)

The committee *recommends* that this item be approved.

Adopted

6. **Credentials** (page 310)

The committee *recommends* that this item be approved.

Adopted

7. **Resolutions:**

a. **Employment of Full-Time Professional Legislative Representative** — Resolution #2 (page 371)

b. **Appointment of County Legislative Keymen** — Resolution #20 (page 382)

c. **Employment of Full-Time Professional Legislative Representative** — Resolution #22 (page 384)

d. **Engagement of Legislative Personnel** – Resolution #24 (page 385)

e. **Engagement of Legislative Personnel** – Resolution #34 (page 391)

Resolutions #2, 20, 22, 24, and 34 were considered together because of their interrelationship.

It was recognized that more effective use of the present system of legislative contacts could be and should be achieved. In the view of the committee, Resolution #20 seemed to offer an effective proposal to improve the keyman system.

The committee *recommends* that Resolution #20 be approved as amended, as follows:

1. In the first paragraph, last line in the wording should be *"is extremely important in protecting health care for the public."*

2. In the fifth paragraph the words "so that there is one Legislative Keyman for each three state Legislators" be amended to read "so that there *are adequate* Legislative Keymen for each of the state Legislators."

With these amendments, the committee *recommends* that Resolution #20 be approved.

Adopted

Your committee offers the following substitute resolution as embodying the constructive elements found in Resolutions #2, 22, 24, and 34.

Whereas, the increasing involvement of government in the health care fields and the expanding importance of health care services of all kinds, put greater demands upon the Society in projecting and protecting its views and purposes with reference to the public welfare; and

Whereas, in consequence a review and reorganization of the Society's legislative educational activities are recognized as immediately desirable, now therefore be it

RESOLVED, that the Council on Legislation, with the approval of the Board of Trustees, proceed to a tightening up of the legislative keyman process and any other aspects of the legislative educational operation that can be improved; and be it further

Following paragraph amended by the House as indicated by small type:

RESOLVED, that, as indicated and necessary, the Council on Legislation, with the approval of the Board of Trustees, designate and use the services of a selected member or members of MSNJ **or any other legislative assistant** as official legislative liaison agents of the Society.

The committee *recommends* approval of the substitute resolution.

Adopted as amended by the House

f. **Conduct of Meetings of the Board of Trustees** – Resolution #23 (page 384)

g. **Membership on MSNJ Board of Trustees and State Board of Medical Examiners** – Resolution #33 (page 391)

Resolution #23 and #33 were *withdrawn* by their sponsors.

h. **Membership on MSNJ Board of Trustees and State Board of Medical Examiners** – Resolution #25 (page 386)

The committee *recommends* that this resolution be not adopted.

Adopted

i. **Osteopathy** – Resolution #35 (page 392)

The committee *recommends* that this resolution be referred to the Committee on Revision of Constitution and Bylaws, because approval of this resolution would be contrary to the Charter and Constitution and Bylaws of MSNJ as they now exist.

Adopted

Report as a whole, as amended, adopted

Reference Committee "B"

David B. Allman, M.D., Chairman

Reference Committee "B" met on Sunday, May 19, 1968, with all members present: Doctors Louis B. McAfoos, Jr., Ernest C. Hillman, Jr., Isaac N. Patterson, Robert A. Weinstein, and the chairman. Approximately twenty (20) delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

a. **Academy of Medicine of New Jersey** (supplemental #2, page 302)

The committee *recommends* approval of the report as presented. However, the committee suggests that there be at least two months' advance notice of programed meetings. Supplemental information revealed that 75 meetings in 16 counties and 6 major symposia were held throughout the State in the past year.

Adopted

b. **Project Hope** (supplemental #1, page 296)

The committee *recommends* approval of the report as submitted.

Adopted

2. **Treasurer** (page 286)

The committee *recommends* approval of the report as submitted, but suggests incorporation of the following in future reports:

a. Auditor's report of the previous year;

b. Nature of investment and yield;

c. Simplification of the report as the Treasurer may deem practical.

Adopted

3. **Finance and Budget** (page 311)

The committee *recommends* approval of the report as submitted.

Adopted

4. **Medical Student Loan Fund** (page 320)

The committee *recommends* approval of the report, and further *recommends* an increase from the present maximum allowance of $1,000 per year per student to a more realistic figure of $1,500.

Adopted

5. **Publication** (page 324)

The committee *recommends* approval of the report as submitted, and expresses its commendation of the excellent progress being made.

Adopted

6. **Resolution:**

Annual Financial Report — Resolution #28 (page 389)

The committee *recommends* approval of the resolution, which is incorporated in item (2) above.

Adopted

Report as a whole adopted

Reference Committee "C"

John J. Crosby, Jr., M.D., Chairman

Reference Committee "C" met on Sunday, May 19, 1968, with all members present: Doctors Anthony P. DeSpirito, Karl T. Franzoni, Robert E. Fullilove, Jr., Mario A. Pastore, and the chairman. Approximately 60 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** – Items

a. **AID Program** (Supplemental #2 page 301)

The Committee *recommends* approval of Supplemental Report #2 of the Board of Trustees and its recommendation. The Committee further *recommends* that the AID Program be under continual review to improve its operation.

Adopted

b. **Blood Insurance Program** (page 294)

The Committee *recommends* approval of this item.

Adopted

c. **Blue Cross-Blue Shield "65" Program** (Supplemental #1, page 300)

The Committee *recommends* approval of this item.

Adopted

d. **Homemaker-Home Health Aide Project** (page 294)

The Committee *recommends* approval of a pilot program to estimate the effectiveness and usefulness of Homemaker-Home Health Aide in hospital utilization.

Adopted

e. **MSP Board of Trustees Composition** (Supplemental #1, page 297)

The Committee *recommends* approval of this item.

Adopted

f. **MSP Board of Trustees – Nominations** (page 293)

The Committee *recommends* approval of this item.

Adopted

g. **MSP Prevailing Fee Program** (Supplemental #1, page 297)

The Committee *recommends* approval of this item.

Adopted

h. **Payments for Services of Hospital-Based Specialists** (Supplemental #1, page 299)

The Committee *recommend* approval of the action of the Board reported in this item.

Adopted

i. **Physicians' Fees Under OCHAMPUS** (page 294)

The Committee *recommends* approval of this item.

Adopted

2. **Medical-Surgical Plan of New Jersey** (page 359)

The Committee thanks the Plan for its work in behalf of the Society and *recommends* approval of this report.

Adopted

3. **Resolutions:**

a. **Discontinuance of AID Program** – Resolution #15 (page 379); Resolution #30 (page 390)

The Committee agrees with the Board of Trustees that the AID Program is indeed helpful toward better utilization of hospital beds and therefore *recommends* that Resolution #15 be not adopted.

Adopted

The Committee for the same reason as expressed in the previous paragraph, *recommends* that Resolution #30 be not adopted.

Adopted

b. **Discontinuance of AID Program** — Resolution #32 (page 391)

For identical reasons as expressed in the previous paragraphs, the Committee *recommends* that Resolution #32 be not adopted.

Adopted

c. **Assignment of Payment for Medical/Surgical Care** — Resolution #18 (page 381)

The Committee noted that this Resolution disregards the fact that assignment is already available under MSP coverage — the most important one for New Jersey physicians — for all who enroll as participating physicians. Some commercial carriers also make assignments available. In light of the foregoing, the Committee *recommends* that Resolution #18 be not adopted.

Reference Committee recommendation not approved

Resolution #18 adopted as amended by the House

Report as a whole, as amended, adopted

Reference Committee "D"

Peter H. Marvel, M.D., Chairman

Reference Committee "D" met on Sunday, May 19, 1968, with all members present: Doctors Edward M. Coe, Warren E. Crane, William R. Muir, John Scillieri, and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. **Medical Defense and Insurance** (page 314 and supplemental, page 315)

The detailed report so cogently and capably presented by Fred A. Mettler, M.D., Chairman was discussed in much detail.

Reference Committee "D" *recommends* the approval of the report of the Committee on Medical Defense and Insurance and of the following specific *recommendations:*

(1) That the E. & W. Blanksteen Agency be continued as the official broker for our Accident and Health, Life, High-Limit Accident, and Major Expense Programs.

(2) That the Employers Insurance of Wausau be engaged as the official professional liability insurance carrier for The Medical Society of New Jersey for 1968-69.

(3) That Joseph A. Britton be designated as MSNJ's official broker for its professional liability insurance coverage.

Adopted

2. **Medical Education** (page 319)

Reference Committee "D" considered the report of the Committee on Medical Education as submitted by Sherman Garrison, M.D., Chairman. The Committee *recommends* approval of the report with the following contained *recommendation:*

That a representative of this committee be sent to the annual meeting of the American Medical Association's Council on Medical Education, as official representative of MSNJ.

Adopted

3. **Medicine and Religion** (page 358)

The report of the Committee on Medicine and Religion as presented by Jerome G. Kaufman, M.D., Chairman was discussed. The Committee *recommends* approval.

Adopted

4. **Retirement Plan for Physicians** (page 358)

The report of the Committee on Retirement Plan for Physicians as submitted by Nicholas E. Marchione, M.D., Chairman was discussed. Reference Committee "D" *recommends* that the report be approved.

Adopted

In view of the plethora of plans available to physicians and liberalizations of the Keogh Law, the physician is faced with a confusing selection of various plans. Therefore, Reference Committee "D" *recommends* that:

The Committee on Retirement Plan for Physicians review these selections and distribute information to the membership of MSNJ.

Adopted

5. **Resolutions:**

a. **Hospital Chaplaincy Programs** — Resolution #6 (page 374)

The Committee *recommends* that Resolution #6, submitted by the Essex County Medical Society be approved.

Adopted

b. **Professional Liability Insurance Audit** — Resolution #11 (page 377)

The Committee studied this Resolution but concluded that it is unnecessary because the matter referred to in the Resolution is contained and dealt with in the report of the Committee on Medical Defense and Insurance. The Committee *recommends* that Resolution #11 be not approved.

Adopted

Report as a whole adopted

Reference Committee "E"

I. Edward Ornaf, M.D., Chairman

Reference Committee "E" met on Sunday, May 19, 1968, with all members present: Doctors Robert C. Anderson, Leonard Brown, Charles H. Calvin, John A. Surmonte, and the chairman. Approximately 17 delegates and members were present, as well as E. Powers Mincher, to discuss the various items under consideration.

1. **Board of Trustees** — Items

JEMPAC (page 294)

The following has been taken from page 294 of the Annual Reports to the 1968 House of Delegates:

The 1967 AMA House urged that leaders and members of local organizations continue support of their own state PAC organization (JEMPAC) as well as AMPAC. The Board reiterated its encouragement of members, as individual physicians, to join and support both JEMPAC and AMPAC. The Board authorized the establishment of a conference committee with JEMPAC to improve communication and exchange of ideas.

The reference committee agrees with the action taken, urges the membership to give strong support to JEMPAC and AMPAC, and *recommends* approval of this item.

Adopted

2. **Legislation** (page 331 and Supplemental Reports #1, page 336, and #2, page 338)

The committee recommends approval of these reports with the exception of the portion dealing with the bill – S-187. The committee recommends that the position on this bill be changed from "no action" to "approved," in recognition of the fact that S-187 would afford free choice of physicians to those covered under Workmen's Compensation.

Your committee therefore *recommends* approval of these reports as amended.

Adopted

In perusing the report of the Council on Legislation, including Supplements #1 and #2, we were impressed with the volume of work and coverage involved. We feel that Doctor McCall, the chairman, and the members of his Council and the assisting staff deserve commendation for a job well done.

Adopted

3. **Public Relations** (page 354)

The report of the Council on Public Relations was reviewed. We agree that "there must be a constant awareness on the part of all members of their individual responsibility for good public relations."

This report should impress the membership with the importance of the work of this Council. Its members deserve our thanks for a job well done. Your committee *recommends* approval of this report.

Adopted

4. **Resolutions**

a. **Regulation of Hypnosis for Medical Purposes** – Resolution #4 (page 373)

This committee wishes to bring these points to your attention:

(1) The only persons who are permitted by law to practice hypnosis for medical treatment are licensed physicians, dentists, and clinical psychologists. Any other persons engaged in treatment by hypnosis are breaking the law and should be reported to the proper authorities.

(2) The statement that entertainment hypnosis should not concern us cannot be accepted. From the Annual Report of the Council on Legislation (page 332) we learn that the 1960 House presented a directive to prohibit entertainment hypnosis. Similar legislation has been supported by the Society in 1963, '64, '65 and '66. The Ocean County Medical Society has agreed to be responsible for the introduction of such legislation this year.

(3) The suggestion that the hypnotist be certified by New Jersey Registry is unnecessary, since the only persons authorized by law to practice hypnosis therapy, are licensed physicians, dentists, and clinical psychologists.

For these reasons your committee *recommends* that Resolution #4 be not approved.

Adopted

b. **Community Health Week in the Spring** – Resolution #5 (page 374)

This resolution presents good reasons why the AMA should have "Community Health Week" in the spring instead of in the third week of October.

One communication received from the AMA suggested that organizations may establish and support "Community Health Week" at will. The committee agrees with the Essex County Medical Society's viewpoint that by doing so we might lose our punch by not coordinating with national media releases and programs.

Nevertheless, this committee *recommends* that we go on record approving Resolution #5 to further stress the desirability of the spring date.

Adopted

c. **House Staff Physicians in Community Hospitals** – Resolution #21 (page 383)

Because of the scarcity of interns and residents in community hospitals in New Jersey, this resolution recommends that The Medical Society of New Jersey appeal to the State Board of Medical Examiners to seek legislation to permit community hospitals to hire unlicensed physicians, when necessary, to perform functions of interns and residents, for an aggregate time of no more than two years. The resolution created much discussion and brought forth many points which were important in formulating our final decision.

The members of the committee and the majority of the participants were sympathetic to the problem at hand. However, numerous examples were given where hospitals hired full-time licensed physicians for emergency ward coverage (Alexandria Plan), or where complete coverage was supplied by part-time physicians (Pontiac Plan). It was also pointed out that formulation of intravenous teams and assignment of paramedical personnel to duties such as catheterizations are of great help. We are mindful of the fact that this does not take care of all duties assigned to house staff physicians, and in some instances results in hardship and inconvenience to staff physicians. However, these needs must be resolved by hospitals on individual basis.

On the other hand such legislation is fraught with certain dangers and might open up "Pandora's box" for additional legislation seeking to give privileges to special groups. Furthermore, the State Board of Medical Examiners is not obligated to pursue recommendations of this House or any other group.

In relation to this subject, we note that S-655 —a bill to provide that the prohibitory provisions of the Medical Practice Act shall not apply to employees of a municipal hospital — was disapproved by the Council on Legislation because MSNJ feels that it is contrary to the public interest to entrust the care of patients to unlicensed physicians other than interns and residents in an approved training program. Such a measure would jeopardize the accreditation of a hospital, because the Joint Commission on the Accreditation of Hospitals prohibits such use of unlicensed physicians.

The committee *recommends* that Resolution #21 be not approved.

Adopted

The Chairman is appreciative of the cooperation and help offered by members of the reference committee and the assistance and advice of Mr. E. Powers Mincher, Legislative Analyst, and Doctor Jesse McCall, Chairman of the Council on Legislation.

Report as a whole adopted

Reference Committee "F"

Elbert H. Pogue, M.D., Chairman

Reference Committee "F" met on Sunday, May 19, 1968, with all members present: Doctors Irving Chrisman, John C. Clark, Robert G. Stineman, Alan A. J. Stolow, and the chairman. Mr. W. C. White, Prudential Life Insurance Company was present as a guest, and Doctor Roy T. Forsberg acted as sergeant-at-arms. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

a. **Generic Versus Proprietary Drugs** (page 295)

The reference committee *recommends* approval of this report as submitted.

Adopted

b. **Health Facilities Planning Council** (page 295)

The committee *recommends* approval of this report. The committee wishes to emphasize a portion of this report: i.e., that the Society's support of the Council is contingent upon the organization remaining a voluntary association, with its findings and recommendations continuing as advisory and not controlling.

Adopted

c. **Payments of Interns and Residents** (page 294)

The committee *recommends* approval of this report.

Adopted

2. **Medical Services** (page 340)

The introduction to this report pointed out that in addition to the duties of the Council on Medical Services stated in the Bylaws has now been added the responsibility to study and provide recommendations concerning all aspects of Medicare and Medicaid programs as they operate, or will operate, in New Jersey, and the maintenance of quality medical care.

a. **Physicians' Complaints Against Workmen's Compensation** (page 340)

The committee *recommends* approval of this portion of the report.

Adopted

b. **Articles on Rehabilitation** (page 340)

The committee *recommends* approval of this portion of the report.

Adopted

c. **Referral from the Board of Trustees** (page 340)

There was considerable discussion of this item which is concerned with the utilization of physicians' services under Part B of Medicare. The Board of Trustees approved the following recommendation, subject to concurrence of the House of Delegates:

(1) That a committee be set up on State level to screen those cases which the fiscal intermediary feels may involve a question of medical ethics or professional conduct under Part B of Medicare.

(2) That the screening committee consist of five members to be appointed by the Board of Trustees, one from each of the Judicial Districts of The Medical Society of New Jersey, with a representative from Prudential Insurance Company (the fiscal intermediary for Part B of Medicare) as a consultant.

The report states further —

If such a screening committee should find a reasonable basis for a claim of unethical or unprofessional conduct in the matter referred by the fiscal intermediary, a complaint would be filed by the screening committee with the judicial committee of the component society having jurisdiction over the physician in question.

As the discussion progressed, it was clear that the delegates and members present were in accord on one vital point — that action should be taken when it becomes clear that there is reason to believe that unethical or unprofessional acts have been committed, or where there is reason to suspect that the element of fraud exists. The basis of disagreement was also clear; namely, should the recommendations of the Board of Trustees be approved as submitted; should the fiscal intermediary be advised to submit complaints directly to the various county judicial committees; or should each component society establish and encourage its own utilization committee to review such cases.

It was pointed out that several component societies have active utilization committees, and that these committees have been effective in correcting abuses occurring under Part B of Medicare. It was also pointed out that the fiscal intermediary under Part B of Medicare employs several members of this Society as consultants whose function is to advise the intermediary about problems of this nature.

Reference Committee "F" therefore *recommends:*

(1) that the House of Delegates not approve the recommendations of the Board of Trustees in this matter;

(2) that any component society which does not have a utilization committee, establish such committee and encourage it to be active and diligent in dealing with this problem; and

(3) that the fiscal intermediary be advised that it should file a complaint with the judicial committee of the component society when it feels (after due consultation with its medical consultants and advisors) that such action is indicated.

Foregoing paragraph amended by the House to read:

(3) that the fiscal intermediary be advised that it should file a complaint with the proper committee of the component society — utilization or judicial committee — when it feels (after due consultation with its medical consultants and advisors) that such action is indicated.

Adopted as amended by the House

d. **Title XIX in New Jersey** (page 341)

The Committee wishes to point out Title XIX legislation must be enacted by 1970, and that despite the fact that little has been published or put into final form, certainly many aspects of the legislation are now being considered by interested parties. The committee feels strongly that unless The Medical Society of New Jersey continues to be well represented in the early planning stages, we may end up with an "11th hour" type of legislative action which we will be forced to accept.

To avoid such a situation, the committee *recommends:*

(1) that the portion of the report dealing with Title XIX be approved;

(2) that the Board of Trustees of The Medical Society of New Jersey take steps to create a joint committee with the State Department of Institutions and Agencies for the purpose of discussing all aspects of Title XIX legislation in New Jersey, and that this committee be encouraged to confer with the legislators as often as necessary, in order to insure that just and fair legislation be enacted; and

(3) that should it prove necessary, a special session of the House of Delegates be called to consider aspects of Title XIX legislation in New Jersey.

Adopted

3. **Occupational Health, Workmen's Compensation, and Rehabilitation** (page 342)

The committee *recommends* approval of this report.

Adopted

4. **Resolutions:**

a. Resolution #1 — **Joint Commission on Accreditation of Hospitals** (page 371) . . . from the Bergen County Medical Society; Resolution #13 — **Physicians on Hospital Governing Boards** (page 378) . . . from the Morris County Medical Society; and Resolution #16 — **Inclusion of Physicians on Hospital Boards** (page 380) . . . from the Union County Medical Society — were considered jointly as the three concern the same matter. After careful review of these resolutions, the committee wishes to offer a substitute resolution embodying features found in Resolutions #1, 13, and 16:

Whereas, increasingly hospitals are becoming centers of medical care and are becoming more and more involved with the practice of Medicine; and

Whereas, the governing bodies of said hospitals are comprised of members of the community who are interested in and dedicated to community health; and

Whereas, members of the medical staffs of said hospitals, by virtue of their profession, are interested in and dedicated to the health of the community; and

Whereas, physicians possess unique knowledge of patients and patient-care which would be of inestimable value to hospital boards of trustees in furtherance of the public interest; and

Whereas, in June 1966, the House of Delegates of the American Medical Association declared it to be the policy of the American Medical Association that hospital governing boards be urged to include physicians in their membership; now therefore be it

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to introduce an appropriate resolution in the AMA House of Delegates urging the Joint Commission on Accreditation of Hospitals to include in its basic accreditation criteria a provision that each hospital be required to include a representative number of physicians in active practice on its governing body.

Foregoing paragraph amended by the House, to read:

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to introduce an appropriate resolution in the AMA House of Delegates urging the Joint Commission on Accreditation of Hospitals to include in its basic accreditation criteria a provision that each hospital be required to include a substantial number of physicians in active private practice on its governing body.

The committee *recommends* approval of this resolution.

Adopted as amended by the House

b. **Specialty Services to Welfare Recipients** — Resolution #7 (page 375) . . . from the Essex County Medical Society

The committee *recommends* approval of this resolution.

Resolution #7 amended by the House

Adopted as amended by the House

c. **Reasonable and Customary Fees for Welfare Recipients** — Resolution #8 (page 375) . . . from the Essex County Medical Society

The committee *recommends* approval of this resolution.

Resolution #8 amended by the House

Adopted as amended by the House

d. **New Methods of Medicare Payments** — Resolution #17 (page 381) . . . from the Warren County Medical Society

The committee *recommends* disapproval of this resolution.

Adopted

e. **Standardized Insurance Forms** — Resolution #31 (page 390) . . . from the Camden County Medical Society

The committee *recommends* that this resolution be approved in principle.

Adopted

The chairman wishes to thank the members of Reference Committee "F" for their services. He also wishes to thank the delegates and members who took part in the discussion.

Report as a whole, as amended, adopted

Arthritis Handbook For Patients

The Arthritis Foundation has released a handbook for patients, called *Osteoarthritis*. It consists of twenty pages of authoritative answers on symptoms, diagnosis, and management of osteoarthritis. While not written down, it is worded so that the intelligent layman may be able to understand the text. Single copies are free. If you are interested in a supply for your patient, write to the Arthritis Foundation, Box 2525, New York.

Reference Committee "G"

Rudolph G. Matflerd, M.D., Chairman

Reference Committee "G" met on Sunday, May 19, 1968, with all members present: Doctors Charles W. Boozan, Francis M. Brower, II, Charles P. Campbell, Walter E. Corrigan, and the chairman. Thirty-four delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **External Cardiopulmonary Resuscitation** (supplemental #1, page 300)

The committee *recommends* approval of this report.

Adopted

b. **Heart Disease, Cancer, and Stroke** (page 295)

The committee *recommends* approval of this report.

Adopted

c. **Smoking in Hospitals** (page 295)

The committee *recommends* approval of this report with the suggestion that The Medical Society of New Jersey take a vigorous stand against all forms of tobacco.

Adopted

d. **Therapeutic Abortion** (supplemental #2, page 301)

The committee *recommends* approval of the Board's recommendation, concurred in by the Committee on Maternal and Infant Welfare.

Adopted

The committee suggests that, in protection of physicians who on moral or religious grounds prefer not to perform abortions, legal immunity be sought and established.

Adopted

2. **Mental Health** (page 343)

The committee *recommends* approval of this report.

Adopted

3. **Alcoholism** (page 344)

The committee *recommends* approval of this report.

Adopted

4. **Drug Addiction** (page 344)

The committee *recommends* approval of this report.

Adopted

5. **Emotional Disorders of Childhood and Adolescence** (page 346)

The committee *recommends* approval of this report.

Adopted

6. **Mental Retardation** (page 346)

The committee *recommends* approval of this report.

Adopted

7. **Seizures** (page 345)

The committee *recommends* approval of this report.

Adopted

8. **Public Health** (page 347)

The committee *recommends* approval of this report.

Adopted

9. **Air Pollution Control** (page 348)

The committee *recommends* approval of this report.

Adopted

10. **Cancer Control** (page 349)

The committee *recommends* approval of this report.

Adopted

11. **Child Health** (page 350)

The committee *recommends* approval of this report.

Adopted

12. **Conservation of Vision** (page 351)

The committee *recommends* approval of this report.

Adopted

12. **Maternal and Infant Welfare** (page 353)

The committee *recommends* approval of this report.

Adopted

14. **Resolutions:**

a. **Health Insurance for Pregnancy** – Resolution #9 (page 376)

The committee *recommends* approval of this resolution.

Resolution #9 adopted as amended by the House

b. **Health Insurance for Complications of Pregnancy** – Resolution #10 (page 376)

The committee *recommends* approval of this resolution.

Adopted

c. **Statement on Abortion** – Resolution #12 (page 377)

The committee *recommends* approval of this resolution.

Adopted

d. **Separate State Department of Mental Health and Mental Retardation** – Resolution #14 (page 378)

The committee *recommends* approval of this resolution with the following revisions:

Paragraph two, line five, insert "a situation" after "oriented authority."

Paragraph four, lines three and four, delete "and Mental Retardation" after "Department of Mental Health."

Paragraph five, line five, delete "and Mental Retardation," after "Department of Mental Health."

Not adopted

Resolution #14 disapproved by the House

Report as a whole, as amended, adopted

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

Reference Committee "H"

Roy A. Morrow, M.D., Chairman

The Reference Committee "H" met on Sunday, May 19, 1968, with all members present: Doctors Harry W. Fullerton, Jr., Seymour F. Kuvin, Blackwell Sawyer, Joshua N. Zimskind, and the chairman. Approximately 8 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

a. **Diploma Schools of Nursing** (page 295)

The committee *recommends* that the foregoing item be approved.

Adopted

2. **Annual Meeting** (page 307)

The committee *recommends* that the report be approved.

Adopted

3. **Emergency Medical Care** (page 356) and supplemental (page 357)

The committee approved the report, with the suggestion that the following sentence be deleted from the report. "It was also suggested that they receive refresher training every year and be licensed by the State based on model standards that were brought out last spring," because this sentence makes reference to another preceding sentence which was deleted from the report by the Special Committee on Emergency Medical Care. (page 357, item 3)

Adopted

4. **Honorary Membership** (page 310)

The committee *recommends* that the report be approved.

Adopted

5. **Traffic Safety** (page 358)

The committee *recommends* that the report be approved.

Adopted

6. **Woman's Auxiliary Advisory** (page 330)

The committee *recommends* that the report be approved.

Adopted

7. **Nominations for Emeritus Membership** (page 369 and supplemental, page 369)

The committee *recommends* that the report be approved, with the exception of one nominee from Somerset County, Abram Levy, M.D., who requested that his name be deleted from the list.

Adopted

8. **Resolutions:**

a. **Revision of FAA Medical Examination Form for Pilot Certification** — Resolution #3 (page 373)

The committee *recommends* that the resolution be adopted.

Adopted

b. **Determination of Safety or Competence of Automobile Drivers** — Resolution #19 (page 382)

It was the committee's opinion that the subject of the resolution be kept in the field of medicine but basically that the resolution should be returned to the sponsor for better wording and clarification; and subsequently, that the content of the resolution should be studied by the Society's Committee on Traffic Safety for deliberation with the New Jersey Division of Motor Vehicles. Therefore, the committee *recommends* that this resolution be not approved.

Adopted

Report as a whole adopted

Reference Committee On Constitution And Bylaws

Raymond A. McCormack, Jr., M.D., Chairman

Reference Committee on Constitution and Bylaws met on Sunday, May 19, 1968, with all members present: Doctors Arthur C. Dietrick, Leonard E. Ellenbogen, Nathan J. Plavin, Adolph R. Wichman, and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

2. **Amendment to the Constitution** (page 329) — SECOND YEAR . . .

The reference committee *recommends* consideration of this amendment as the first order of business under the second year procedure as outlined in the Constitution (Article II, B).

In view of the action of the 1967 House of Delegates, the reference committee *recommends* adoption of this amendment by the House.

Adopted

2. **Proposed Amendments to the Constitution**

Article VI — Board of Trustees . . . from the Bergen County Medical Society (page 326)

a. **Exhibit #1** (page 327 of the report from the Committee on Constitution and Bylaws)

b. **Resolution #26** (page 386)

These two proposals were grouped together for consideration, because of their interrelationship in the discussion before the reference committee.

Lengthy discussion was held on these two proposals. The intent seemed evident that paragraph 1 of the amending portion of Resolution #26 sought to amend paragraph 1 of Exhibit #1 to keep the number of Trustees from becoming unwieldy. The reference committee felt that this objective has merit.

It was felt that the proposed substitution of paragraph 1 of Resolution #26, offered by its introducers, which was suggested in place of paragraph 1 of Exhibit #1 is a substantive change of Exhibit #1, because Resolution #26 would reduce from 2 to 1 the Trustees from the Fifth Judicial District without the prior knowledge and consideration of the counties in District Five.

In view of this consideration — and the fact that Resolution #26 does not conform to the normal constitutional procedure, your committee *recommends* that Resolution #26 be referred to the Society's Standing Committee on Constitution and Bylaws, for study and report to the 1969 House of Delegates.

Adopted

In view of the foregoing and the impression given before the reference committee that Resolution #26 was offered as more equitably and adequately expressing the feeling of the Bergen County Medical Society — the reference committee *recommends* disapproval of Exhibit #1.

Adopted

3. **Amendments to the Bylaws**

a. **Chapter V — Procedure of Election, Section 1, Nominating Committee . . . from the Essex County Medical Society — Exhibit #2** (page 327)

The reference committee concurs with the evaluation of this proposal made by the Society's Standing Committee on Revision of Constitution and Bylaws, as outlined on page 325 items 1 through 5, namely:

(1) Every county has equal opportunity to submit names of candidates for office.

(2) The right to nominate from the floor gives adequate protection and representation to the more populous counties who have qualified candidates for offices they want recognized.

(3) The Committee functions smoothly and efficiently, without reference to pressure from geographical influence.

(4) The entire concept of a Nominating Committee is to select the most qualified candidates to serve on a statewide basis, exclusive of size of county or geographical location.

(5) Qualitative selection is made by the Nominating Committee. Quantitative election is made by the House.

Therefore, the reference committee *recommends* that no change be made in the Nominating Committee and that this amendment be not approved.

Adopted

b. **Chapter I — Membership, Section 2, Lists of Members . . . from the Essex County Medical Society — Exhibit #3** (page 329)

This proposal is to be implemented only for compatability of the Bylaws to Exhibit #2. In view of its recommendation of disapproval of Exhibit #2, the reference committee likewise *recommends* that this proposal be not approved.

Adopted

c. **Chapter VI—Rights and Duties of Officers, Section 5, Board of Trustees (f) State Board of Medical Examiners . . . from the Board of Trustees — Exhibit #4** (page 329)

This proposal is to make the Society's Bylaws consistent with state law concerning submission of nominees for membership on the Board of Medical Examiners of New Jersey.

The reference committee *recommends* approval of this amendment.

Adopted

4. Resolutions

a. **Establishment of Ad Hoc Committee to Redistrict the State to Provide Proportionate Representation on the Board of Trustees — Resolution #27 from a Bergen County Delegate** (page 388)

The reference committee *recommends* that this resolution be referred to the Society's Committee on Revision of Constitution and Bylaws, for study and report to the 1969 House.

Adopted

b. **Amendment to Bylaws Regarding Fiscal Year** — Resolution #29 from Bergen County (page 389)

In light of the many complexities involved in this change that were brought to the attention of the reference committee, it is *recommended* that Resolution #29 be disapproved at this time, with the further *recommendation* that the entire problem be referred to the Society's standing committee on Finance and Budget for further study and report to the 1969 House.

Adopted

Report as a whole adopted

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Report of Nominating Committee and Election—May 19, 1968

Joseph R. Jehl, M.D., Chairman

OFFICE	TERM	ELECTED
President-Elect	1 year	Nicholas A. Bertha M.D., Wharton
1st Vice-President	1 year	Emanuel M. Satulsky, M.D., Elizabeth
2nd Vice-President	1 year	E. Vernon Davis, M.D., Mount Holly
Secretary	1 year	Marcus H. Greifinger, M.D., Newark
Treasurer	1 year	Samuel J. Lloyd, M.D., Trenton
Trustees:		
1st District	3 years	Jerome G. Kaufman, M.D., Maplewood
2nd District	3 years	Thomas C. DeCecio, M.D., Cliffside Park
5th District	3 years	Nicholas E. Marchione, M.D., Vineland
Judicial Councilors:		
2nd District	3 years	John L. Olpp, M.D., Englewood
4th District	1 year*	I. Edward Ornaf, M.D., Camden
5th District	3 years	John S. Madara, M.D., Salem
AMA Delegates:	2 years	John F. Kustrup, M.D., Trenton
	2 years	Marcus H. Greifinger, M.D., Newark
	2 years	Frank J. Hughes, M.D., Camden
	2 years	Luke A. Mulligan, M.D., Leonia
AMA Alternate Delegates:	2 years	John J. Bedrick, M.D., Bayonne
	2 years	Matthew E. Boylan, M.D., Jersey City
	2 years	Louis F. Albright, M.D., Spring Lake
	2 years	Jerome G. Kaufman, M.D., Maplewood
Delegates and Alternate Delegates to Other States:		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Trenton
Alternate	1 year	Josiah C. McCracken, M.D., Ventnor City
Connecticut:		
Delegate	1 year	Lloyd A. Hamilton, M.D., Lambertville
Alternate	1 year	Frank W. Konzelmann, M.D., Somers Point
Administrative Councils:		
Legislation:		
1st District	3 years	Harvey P. Einhorn, M.D., South Orange
4th District	3 years	Meyer L. Abrams, M.D., Willingboro
Medical Services:		
1st District	3 years	Francis J. Benz, M.D., Chatham
4th District	3 years	Robert S. Gamon, Jr., M.D., Camden
Mental Health:		
1st District	3 years	Arnold Kallen, M.D., Newark
2nd District	3 years	Eugene V. Resnick, M.D., Paramus
Public Health:		
1st District	3 years	Edward G. Bourns, M.D., Union
4th District	3 years	Frederick P. Steller, M.D., Spring Lake
Public Relations:		
1st District	3 years	S. William Kalb, M.D., Newark
4th District	3 years	John P. Kengeter, M.D., Toms River
Standing Committees:		
Annual Meeting	3 years	James A. Rogers, M.D., Paterson
Finance and Budget	3 years	G. Thomas DeFusco, M.D., Deal
Medical Defense and Insurance	3 years	Jesse Schulman, M.D., Lakewood
Medical Education	3 years	Irving M. Rollins, M.D., South Orange
Publication	3 years	James J. Fitzpatrick, M.D., Trenton
Woman's Auxiliary Advisory	3 years	Ralph K. Bush, M.D., Merchantville

Adopted as amended: Dr. I. Edward Ornof of Camden County was nominated from the floor — and elected by the House — to fill the unexpired term of one year on the Judicial Council from the 4th District, created by Dr. E. Vernon Davis' election to the office of Second Vice-President. All other nominees were elected to the designated offices for the terms indicated.

* To fill unexpired term

GENERAL SESSION

Sunday Afternoon, May 19, 1968

The General Session was convened at 4:00 p.m., Louis K. Collins, M.D., President, presiding.

Dr. Collins: The ladies came here early. They were going to spend all their husbands' money for the fashion show, but they rushed over here to hear John Kustrup and Dwight Wilbur. So it's very nice of them to save our money.

Welcome to the Sunday afternoon General Session at this 202nd annual meeting. We are patterning something after the AMA. We are giving recognition to our County Presidents, and as I call the roll of the County Presidents will they please come forward and take their seats?

For Atlantic County, Leonard B. Erber, M.D.

For Bergen County, Stewart F. Alexander, M.D.

For Burlington County, Irwin S. Smith, M.D.

For Camden County, William A. Halbeisen, M.D.

For Cape May County, Norris D. Bunn, M.D.

For Cumberland County, Mario A. Pastore, M.D.

For Essex County, a familiar name, William Greifinger, M.D.

For the best county of all, Gloucester, John W. Holdcraft, M.D.

Now, we have a couple scratches here. For Hudson County, William Yudkoff, M.D.

And for Bernard L. Schapiro, M.D. of Hunterdon County, Vladimir F. Ctibor, M.D.

For Mercer County, Karl T. Franzoni, M.D.

For Middlesex County, Charles Gandek, M.D.

For Monmouth County, Anthony P. DeSpirito, M.D.

For Morris County, Henry O. von Deilen, M.D.

For Ocean County, John P. Kengeter, M.D.

For Passaic County, Irving Chrisman, M.D.

For Salem County, Samuel P. Reed, M.D.

For Somerset County, Arthur W. Culberson, M.D.

For Sussex County, Charles L. Ringe, M.D.

For Union County, George L. Erdman, M.D.

And for Warren County, Nathan I. Kantor, M.D.

(Applause)

Now, if I have missed any County Presidents please correct me. When I was on the platform when the AMA was down here, they missed one of the State Presidents and he sat and sat and sat. They skipped him right by. I hope I haven't done that.

I'd like to introduce some of your new officers who were just elected today:

Our New President-Elect, Nicholas A. Bertha.

(Applause)

Your First Vice-President, Emanuel M. Satulsky.

(Applause)

And seated in the audience, Vernon Davis, Second Vice-President.

(Applause)

Now, will Dr. Albert Moriconi please escort Mrs. Kustrup to the stage?

(Standing ovation)

I don't know who is going to run this family now with two Presidents. It's going to be a tough job.

Dr. Moriconi has a few words.

Dr. Albert F. Moriconi: I don't think that was a very fine introduction on the part of the President. However, I'll respect him. I'm stuck.

Mr. President, Mrs. Kustrup, President-Elect of the Woman's Auxiliary — you know, this Kustrup family is really quite famous — House of Delegates, President-Elect John F. Kustrup, Members of the Board of Trustees, Honored Guests and Distinguished Ladies and Gentlemen:

It gives me great pleasure as a delegate from Mercer County to introduce our new President, a man I've known for 37 years. Before I do this, I would like you to know how I was chosen for this job.

Almost two months ago after a surgical committee meeting at St. Francis Hospital, Dr. John F. Kustrup, the Director of Surgery, walked out of the room with me and a dozen other physicians and in a low aside said to me, "Al, I would like you to present me." And that was the last I heard about it in spite of the fact that I must have talked with him at least a score of times afterwards. Lo and behold, last Tuesday Miss Theresa Goeke of the office of our Society called me and asked me for a copy of my speech of presentation. I didn't have any. In consequence, this speech must perforce be short and to the point since I had so little time to prepare it. This may make you people happy but it costs me the opportunity of a lifetime to lull you to sleep with a sonorous and longwinded speech, like some of the members can keep going.

Now about Johnny Kustrup. He was born in Trenton where he has been in practice since 1931. Following pre-medical education at Georgetown University, he was awarded his M.D. degree in 1930. He served his internship at St. Francis Hospital in Trenton where he currently is Director and Chief of Surgery. He did graduate study at the University of Pennsylvania School of Medicine and served a surgical residency at the Wilmington, Delaware, Memorial Hospital.

He is a Fellow of the American College of Surgeons, the International College of Surgeons, a Diplomate of the American Board of Surgery, and a former instructor of pathology at Jefferson Medical School.

Dr. Kustrup is on the courtesy staff of Mercer and Hamilton Hospitals in Trenton and formerly a consulting surgeon to the New Jersey State Hospital and the New Jersey State Prison.

Dr. Kustrup is a member and former President of the following organizations. The Medical Journal Club of Trenton; Mercer County Component Medical Society; Mercer County Catholic Physicians Guild. In addition to his membership in The Medical Society of New Jersey, which he has served in many capacities, and the American Medical Association, Dr. Kustrup holds membership in the New Jersey Society of Surgeons, College of Surgeons of Philadelphia, and the National Federation of Catholic Physicians. He is also a member of the Health Facilities Planning Council of New Jersey.

Doctor and Mrs. Kustrup — the former Eva H. Williams of Washington, D.C. — have a daughter, Elizabeth Kustrup Sheahan of Pelham Manor, New York, and twin sons — John F., Junior, who is a partner in general surgery with his father; and William J., an ophthalmologist — both on the staff of St. Francis Hospital and both are Board men.

A physician-father rarely has one son to follow in his footsteps. Johnny has two and both excellent products — fine gentlemen and physicians. They're going to have to go a long way to catch up with the old man, though.

As you can readily discern, he is a man of many accomplishments and a source of joy and pride to all his close associates, and to the staff and administration of St. Francis Hospital, where we have been fellow-chiefs for many years.

One incident in his life stands out in my mind more than ever since we, in the surgical department at St. Francis, were witnesses to his specific abilities.

Our residency programs in medicine, pediatrics, Ob-Gyn, pathology, and surgery were floundering about in the throes of inadequacy, lack of direction, poor cooperation, inertia, and just plain lack of interest on the part of many members of our staff.

Johnny was made Director of Surgery some years ago and things began to pop immediate-

ly in surgery — surgical rounds, lectures, meetings, et cetera improved. Cooperation improved and the surgical residency was extended from a three to a four-year residency program by the Joint Commission on Accreditation, and then enlarged to include a total of nine residents in surgery, many of whom have since passed their boards in surgery.

On the other hand, our other residencies began to die on the vine and we lost those in medicine and pediatrics. The Ob-Gyn residency is having great difficulty keeping alive. We at St. Francis believe this is a typical example of what Dr. John Kustrup stands for — accomplishment, hard work, devotion to duty, untiring professional ability and ethics of the highest order. And we are sure he will carry this ability, verve and energy into the presidency of our Society.

We believe The Medical Society of New Jersey could not have picked a better man for the presidency, and we in Mercer County are proud and happy that you did.

(Applause)

Dr. Collins: You know, Albert, everyone knows you and I didn't want to make a big speech introducing you.

John, will you stand, please?

We have a few little things here for Dr. Kustrup and I'll read this first:

"The Medical Society of New Jersey presents this testimonial of sincere appreciation to John F. Kustrup, M.D., President, 1968-69, in recognition of his services to the State of New Jersey and to the medical profession."

Now comes a heavy one. You want to get a good nail on your wall before you hang this up, because I know mine fell down twice. It's a very beautiful plaque. And as Joe Jehl told me last year, you can put this on your wall and the people will really know that you are the President, and that's the reason your son is going to do all the surgery and you don't have to do any more work. I have no son to do my work for me. It's the seal of the State Society and it says: "The Medical Society of New Jersey — John F. Kustrup — President, 1968-69."

John, congratulations.

(Applause)

(Dr. Kustrup then gave his Inaugural Address which appears in The June 1968 *Journal,* page 234)

(Standing ovation)

Dr. Collins: While Dr. Moriconi is escorting Mrs. Kustrup from the podium, I'd like to say, John, that was a very comprehensive talk, and since you mentioned the Ladies' Auxiliary I would like to introduce the President-elect of our New Jersey Auxiliary at the moment. Mrs. Olive Zuckerman.

(Applause)

And seated next to her is a former recent Past-president of the AMA Auxiliary, Mrs. Marion Yaguda.

(Applause)

And now while we are on the AMA, the next gentleman I should present to you needs no introduction. He is a Past-president of the American Medical Association, a past-Trustee, our own David B. Allman, who will escort Dr. Wilbur to the podium. Dave.

(Standing ovation)

Dr. David B. Allman: First I want to thank the officers and members of The Medical Society of New Jersey for again bestowing upon me a high honor. You have done much for me during the past years and I am most happy at this time to accept the assignment I have now.

As you all know, I am about to introduce to you the President-Elect of the American Medical Association, Dr. Dwight L. Wilbur. He really needs no introduction. He is well acquainted with most of us. He received his medical education right close to home, here at the University of Pennsylvania and he's been dedicated to medicine, I might say, since he was born because his father before him was also President of the American Medical As-

sociation, and this is the only father-son team in the history of the American Medical Association that has ever held that high office.

Dr. Wilbur entered the House of Delegates of the AMA in 1941. That service was interrupted by the war. He then came back and became a Trustee of the AMA in 1963 and has served in that capacity ever since.

Dr. Wilbur, as I have intimated by the fact that his father was the President of the AMA, has practically been born in medicine and I believe he has done more for the ideals of medicine than any one man I know. I can go on and speak of the virtues of Dr. Wilbur for hours. I am very reluctant to do it, in fact I was reluctant to say anything.

The President of these United States is introduced as "The President of the United States," and I think that Dr. Wilbur is probably entitled to just as much respect and consideration.

Ladies and Gentlemen, I give you Dr. Dwight L. Wilbur.

(Standing ovation)

Dr. Dwight L. Wilbur: Dr. Allman, President Collins, new President Dr. Kustrup, Officers of The Medical Society of New Jersey, members of the House of Delegates and of the Woman's Auxiliary, and Ladies and Gentlemen: One of the most pleasant parts of being in the office that I hold, as Dave Allman I'm sure can tell you, is the opportunity of going around the country and meeting, as I am today, with members of Houses of Delegates of the State Medical Societies. It really is a great pleasure, a very stimulating one and I'm particularly pleased to have the opportunity to speak to the House of Delegates of The Medical Society of New Jersey and to come here on this beautiful California day, because in a way I feel as if I were at home.

(Laughter)

As Dave Allman has indicated, I spent four years in Philadelphia, a good many years ago, and one can t spend time in Philadelphia without spending time in New Jersey. I must say that some of our time then as interns was spent going to the Town of Red Bank where they happened to have not only a good but a very economical supply of Applejack.

(Laughter)

And in those days, being on a salary for two years of room, board and laundry, you can see the price of things was very important.

I am also very pleased to be here to have a chance to tell you that for many years I have been a great admirer of Dr. Allman. I have been in the House of Delegates, I think, most of the time that he served in the House and as a member of the Board of Trustees and then as President. And I particularly remember the address he made at the time of his inauguration because it was one of the best that I have heard and I hope some of you will reach into the archives in the Journal of the American Medical Association and get it out because much of what he said then can be applied to our problems of today.

I am also very pleased to have a chance to see my old friend, Joe Donnelly, who last June was kind enough, upstairs here in the Pennsylvania Room, to get up and second my nomination for President-Elect of the AMA.

Let me further say that I want to congratulate Dr. Kustrup on the excellent inaugural address which he has given, in which he expressed so well those things that are important to us nowadays facing the very difficult problems we do in the practice of medicine.

Now, what I would like to discuss with you briefly this afternoon is what I call a need to plan and I am impressed by the fact, as I am sure you are, that there have been very striking changes in medicine in the last twenty-five years since World War II. From the scientific standpoint let's look back a moment and remember that at that time there were essentially no antibiotics, no corticosteroids, none of the modern tranquilizing agents, es-

sentially no effective cardiovascular surgical procedures. And from the standpoint of the economics of medical care, voluntary health insurance was in its infancy; compulsory health insurance was discussed but had not reached the level that it did subsequently; and at the same time there was essentially little discussion and little need for recognizing the problems of the third person in the physician-patient relationship. But all that's changed now and these very striking alterations in the practice of medicine have come upon us and I think no one taking in the broad sweep of history could help but wonder what lies ahead and recognize that twenty-five years from now the changes in our profession, both scientifically and from the standpoint of the economics of health care, will probably be even greater than those of the last twenty-five years. I'm not at the moment going to say what I think some of these changes will be, but I want to in particular emphasize the reaction that those of us in the profession and in medical societies should take in view of this.

What have we, as a profession, learned in the past twenty-five years in respect to these changes? And what have we learned from the bruising episode that we had in relation to the actions of the 89th Congress? What does the future hold? And perhaps even more important, how can we influence it?

In my mind, clearly three factors stand out as being the most important ones in this change. The first of those will come with increasing knowledge in the prevention, the diagnosis and treatment of disease, the fruits of basic research and clinical investigation. And about these we cannot at this moment make too many predictions.

The second will be very striking changes in the organization and the delivery of health care. Voluntary health insurance is sure to grow. Government financing of medical care is going to increase. There will be further development in the specialization of medicine and the development of group practice. There is going to be a need for more medical manpower and more health facilities. There is going to be increasing demand for medical and health care. There is very clearly going to be an extensive development in the use of hospitals, particularly emergency rooms, laboratories and other of the sophisticated types of services and therapeutic facilities that are available in hospitals. And there is going to be a continued urbanization of our population with all of the attending problems that it brings in relation to health care.

I think without any question the government is going to push for a prepaid, closed panel system of group practice rendering comprehensive and continuing care with lay domination and physicians on salary.

The third and perhaps the most important factor which will influence the future is going to be the fact that we now have a national commitment to health and health care. This is a phenomenon of the 1960's and it was exemplified most in the 89th Congress which passed, as you already know, Medicare, Medicaid, Regional Medical Programs, Comprehensive Health Planning, and the Partnership for Health Laws.

Consider such statements which have come in relation to these laws and to this national commitment:

"Health care is the right of every individual."

"There should be a personal physician for every patient."

"There should be a mainstream medicine for all."

"Health and health care are public responsibilities."

"Local initiative and local control are to be emphasized."

"There is to be no interference with existing patterns of health care."

Surely the federal government is in the financing of medical research, medical education and medical service in a big way, to the extent of 15 to 20 per cent of all the funds going into the health care system at the present time.

Where are we in the medical profession in relation to these developments? Let me pose some questions for you. Who is going to do

the planning in health in the future? Who is going to make the changes that are inevitable and to which I have alluded? Who is going to make the decisions? Will it be the experts and others in the field of public health? Will it be the Congress? Will it be the Executive Branch of government through HEW? Will it be state and local departments of public health? Will it be the unions? Will it be the public? Or will it be the medical profession?

What kind of partnership are we going to have with government and who is going to lead in this partnership?

Basically, public opinion is the most powerful determinant and the ultimate force which, in the long run, will decide the social, economic and political patterns of health care in this country. Who and what will shape public opinion in respect to the patterns of health care?

What will be the role of the individual physician and the local and state medical associations and the AMA?

What are we doing in respect to planning?

Are we going to take an effective role of leadership in cooperating with government, where necessary, and others with a special interest in the health field, or are we by default going to bow out and let others do it, and continue to react and to reject what government, labor, and others do in attempting to socialize the profession of which we are members?

Are we going to preserve the best that's in the private practice of medicine — the physician-patient relationship, the free choice of hospitals and physicians, the fee-for-service, and other principles which we in the profession hold to be so important?

It is essential for the AMA, state, and local medical societies to plan for the future, to plan as never before.

Why do we exist as associations? What are these associations for? Our constitutions generally say "to advance the science and art of medicine and the betterment of the public health." We clearly understand the first, but what do we mean by "betterment of the public health?"

We must develop a clear understanding of what should be the scope and responsibility of medicine in the new era of health care. But equally important, we must establish the purpose and the goals of our societies and of medicine. We must then develop the accurate facts and dependable information in respect to the health care system, and particularly the organization of the delivery of health care, and on the basis of this and what we know, we must then lead constructively.

We must change our attitude about involvement with government and others in the health field. We are involved.

In the political area such knowledge as we possess and can possess, the expertise which we'll have will be the strongest asset of medicine. We must no longer play the passive role and just oppose what they think is bad.

This is not a new role for a physician, accustomed to making a diagnosis by taking a history, by examining a patient, by doing whatever necessary laboratory and radiologic procedures are required, and then, on the basis of this information and his knowledge of the patient before him, to proceed to strengthen what is weak and to repair or cure what is defective, in a positive way.

In the long run, our advice, carefully considered and given, will be successful only if it has the support of public opinion, just as any advice from the physician is likely to be followed only if the patient has confidence in his physician and recognizes the advice as good advice.

The Board of Trustees of the American Medical Association has recently established a committee on planning and development, and this committee and the board are giving serious consideration to some of these questions which I have identified.

I believe that every state and every local medical society should have a similar committee of its most effective, intelligent, and experienced members, particularly those skilled in planning, so that we may effectively plan for what should be our goal; namely, the highest quality of medical care for everyone in America.

I think these committees should include younger physicians because basically it is for them that we are planning, and we must keep in mind that by law under the regional medical programs, the Manpower Facilities Acts, the Comprehensive Planning Laws, that planning is going to be done by some one. I think it is very important that every physician, every member of a hospital staff, plan for what he individually and the hospital staff to which he belongs — what will be their role in the future in the obvious changes that will occur in the medical and health fields.

Our strengths are many, but they will avail us little if we do not plan and lead as only those of us in the medical profession can.

We are as sophisticated, educated, and intelligent as any group in the country. This gives me great hope that we really can effectively plan for the future of our medical profession and our medical societies and for the health care of the American people, but we must individually and collectively plan. We must not fail.

Thank you.

(Standing ovation)

Dr. Collins: Thank you very much Dr. Wilbur, for that very stirring address.

As you know, this will be published with all other Transactions of the House in a later issue of the JOURNAL, so save it, and if you want some reprints, Mr. Nevin will tell you how much they are.

This concludes the General Session. Adjourned.

(The session was adjourned at 5:00 p.m.)

MEDICAL-SURGICAL PLAN

Saturday, May 18, 1968

Joseph P. Donnelly, M.D., President of Medical-Surgical Plan of New Jersey, presided. The discussion convened at 4:25 p.m.

Dr. Collins: Will you please either be seated or leave? Thank you very much.

It looks like we have more members of the Blue Shield Board here than we do members of the Medical Society otherwise, so maybe the discussion won't be too heated.

I had the great pleasure this past year of serving, by virtue of my office, on the Blue Shield as well as the Blue Cross Boards and it was a great revelation to me, and no one who hasn't been with these Boards could realize the difficulties, the trouble, the hard work they do, and the many outside forces that are pressing in on the medical-surgical plans all over the country.

I would like first of all to ask you to rise for a moment of silence in memory of Nicholas F. Alfano, M.D.

(Moment of silence)

Thank you.

I'm not going to say anymore except to announce that Joseph P. Donnelly, M.D. of Hudson County was elected President of the Medical-Surgical Plan of New Jersey at a meeting of the Plan's Board of Trustees held in Newark on Tuesday, April 23, 1968.

Dr. Donnelly has long been identfied with MSP and has served for many years as a member of the MSP Board of Trustees. He has been the Medical Director of the Margaret Hague Maternity Hospital, Jersey City, since 1954. He served three full terms as a member of the Board of Trustees of The Medical So-

ciety of New Jersey, and is Chairman of the New Jersey Delegation to the American Medical Association.

Dr. Donnelly assumed his new duties as MSP President May 1st.

I'm going to now turn the meeting over to Dr. Donnelly. And go easy on him because he's new on the job. Thank you.

(Applause)

Dr. Joseph P. Donnelly: It's a pleasure to welcome you to this open discussion on the Medical-Surgical Plan. And as you all know, discussion is not only on this afternoon but it will take place tomorrow also in Reference Committee "C."

I am well aware, after being on the job two weeks, that I don't have all the answers to the questions, but we do have a full complement of staff here who will be able to assist me and help me answer some of your questions. In fact, I'm afraid that most will be turned over to them because I find myself today with too many hats. I am also on the Nominating Committee which is meeting now. This will be the last time I'll be on it because as President of the Medical-Surgical Plan I can't get involved in too many things. Unfortunately, our alternate delegate is not here either and I have to go down there shortly. But we do have people here to answer your questions.

Before opening the floor to questions and comments, I want to touch very briefly on a few highlights of where we stand in 1968 in Medical-Surgical. Operationally, 1967 was a relatively good year for Blue Shield. We incurred over $53 million in claims and paid out just under $50 million, covering more than one million services — a new record for the plan. Our membership grew by 129,000 people and that membership now stands at over 2,900,000 and very shortly we hope it will go over the three million. We made a slight financial gain and ended the year with reserves equivalent to about one month's claims. This is due to some impact of the Medicare program.

One of the most signficant trends has been the addition of Rider J coverage by large numbers of subscribers. Over a quarter of a million added this extended benefit during the year. As you know, Rider J covers diagnostic and therapeutic services and surgery in the doctor's office or hospital out-patient department, as well as surgery in the office and extra days of medical care in the hospital. This coverage has undoubtedly kept people out of the hospital who otherwise would be hospitalized and we are glad to see it catching on so well with the public.

In line with this, I'm happy to say that this same type of coverage will be offered before long to people enrolled in Blue Cross and Blue Shield in the over 65 program — to complement Medicare. We realize this coverage doesn't do as good a job as we would like to see it, since doctors' services are covered only in the hospital. The reason is primarily economic because when we wrote up this rider we found out it would cost, if we covered services in the doctors' offices, about $12 a month, which would be a prohibitive premium. So we put together a rider which will do this: It will pick up the $50 deductible and 20 per cent co-insurance with the covered services on people over 65, and the services in the doctor's office that would be covered are diagnostic, x-ray, radiation, physical therapy, pathology, and surgery. This will be of advantage to both the patient and the doctor and we hope to have it available by August and it also should cut down on admissions.

There is one more thing I want to mention. A sizeable number of doctors have delayed signing up for the Blue Shield prevailing fee program which has been sent to all of you — for what reasons I don't know. It may be because only a limited number of subscribers were covered by the prevailing fee at first. Well, that's all changed. Before the end of the year nearly a quarter of a million more subscribers will be under the prevailing fee contract. The automotive industry and all the federal employees will be under the prevailing fee. It is a good program for the subscriber. His covered services are paid in full ninety per

cent of the time. It's good for the doctor because it pays his usual, customary, and reasonable charges. It is good for Blue Shield because it keeps the Plan in the forefront of the changes that are taking place in our medical economy.

Mark my words — this program is going to mushroom very fast in New Jersey, as it has in other states where it is operating. So please get aboard. Send in your form so Blue Shield can do a better job for its subscribers and for you.

As a final thought, I don't profess to know all the answers, especially after being on the job just two weeks, but when I got mixed up with this whole program — with Dr. Norton as far back as 1944 — we were again pressed by government insurance, and after all these years the outlook to me is much brighter. At that time it was felt that we were going to have socialized medicine, as we called it, and that the government would do the whole job, that every doctor would be working on a salary basis. And today, whether it be Wilbur Cohen or Governor Rockefeller or any of the social planners who are in the forefront of planning for new medical ways, the one thing that they all come up with is that more and more of this thing should be done through the voluntary plan and through the Blue Shield Plans. This, I think, has been Blue Shield's biggest contribution in the whole thing.

And as a final thought I can tell you this: I am much more hopeful today than I was six years ago or twenty years ago that government programs that finally evolve are going to rely more and more heavily on the private sector of insurance and specifically on Blue Shield. For this reason I am convinced that we doctors need a strong Blue Shield Plan today more than ever before and it's for this reason that I joined the Plan.

I will now introduce the representatives of the Plan who are with me and present them to the audience so that they may help me to answer your questions. John Robinson; Dr. Jerry Rathgesser, Associate Medical Director; Robert Jackson, the Vice-President of Marketing; William Skelly, the Secretary-Treasurer and Comptroller; William Vanderbilt, the counsel; and Frank Romaine, our Public Relations officer.

And at this time, although there are only a few people here — we miss Dr. Alfano greatly, of course, in the Plan for his many years of service, but during his illness there was one man who kept this thing going and I think his services to the physicians of New Jersey and to the Medical-Surgical Plan should certainly be part of the history of this whole movement, and I refer to Dr. Thomas White, who is the Chairman of the Board and who served as President of this Plan for almost a year without any compensation whatsoever. This was a great sacrifice.

(Applause)

The forum is now open for questions. I will say this: I'm anxious to get out. This is my first day before the firing squad. When we come back next year I'll be very happy to take you on, wrestle catch-as-catch-can. But if you will excuse me today, I will appreciate it very much.

If there are no further questions, the meeting is adjourned. Thank you.

Directory of Technicians' Schools

Updated lists of AMA approved or accredited schools, revised to September 15, 1967, are now available from the Department of Allied Medical Professions and Services, AMA, 535 North Dearborn, Chicago, Illinois. Included are AMA approved schools of cytotechnology, inhalation therapy, x-ray technology, physical therapy and medical technology, approved courses in occupational therapy, and accredited schools for medical record librarians and medical record technicians.

DINNER DANCE

Monday Evening, May 20, 1968

Mr. Richard I. Nevin was Toastmaster.

The Toastmaster: It is now my pleasure to introduce Mrs. David E. Zuckerman, President of the Woman's Auxiliary to The Medical Society of New Jersey, who will extend to you an official welcome. Mrs. Zuckerman.

(Applause)

Mrs. David E. Zuckerman: Thank you, Mr. Nevin.

Honored Guests: It is my pleasure to welcome you to this tribute to a wonderful fellow and his lovely and charming wife.

In his farewell address to the House of Delegates, Dr. Collins stated that for several important reasons May 18th was a memorable date for him. We hope that May 20th will rank among his happier memories.

Thank you.

(Applause)

The Toastmaster: According to the program, I am supposed to make some introductions and I am very happy to follow the program. First of all, it says I am to introduce Mrs. John F. Kustrup. She is the wife of the President-Elect of The Medical Society of New Jersey. Incidentally, she is, in her own right, the President-Elect of the Woman's Auxiliary to The Medical Society of New Jersey. Mrs. Kustrup.

(Applause)

And then there is some one who is called John F. Kustrup, M.D. He is the wife (Laughter) — he has a wife. Therefore, having a wife, he is the husband of the President-Elect of the Woman's Auxiliary to The Medical Society of New Jersey. Incidentally, he is the President-Elect of The Medical Society of New Jersey.

(Applause)

I think it will be well if I introduce to you people whom already you know, but this is just formality, you understand, here at the head table.

To the extreme right is Dr. David Zuckerman, himself a distinguished obstetrician and gynecologist, who is the husband to the lovely President of the Auxiliary who welcomed you here just a little while ago.

(Applause)

Now I am in position to relieve my conscience of a great burden which has been on it for a year. I still don't believe it, but I am told that last year I did not introduce the next lady. I have expressed my apologizes to her, and now I should like, one year late, to introduce the wife of the 1967 President of The Medical Society of New Jersey — Mrs. Joseph R. Jehl.

(Applause)

And now, I hope I don't create any scandal, I should like to introduce the same lady as the wife of the immediate Past-President of The Medical Society of New Jersey.

(Laughter and applause)

(Mr. Nevin then proceeded with the introductions.)

The Toastmaster: Some years ago I read an anecdote about Kng George VI when, as a Prince of the line, he was in training in the British Navy. He had a very serious stutter, you know, and by way of trying to help the young Prince to the competence of leadership the Commander of the flat-top to which he was assigned decided one morning that he'd give the young Prince a chance to drill the troops in parade on the deck.

So they were all drawn up and the Commander said: "Your Highness, you may now take over."

The Prince started to make his mouth work

and breathe uneasily and said: "Fu-fu-fu-forward march." And they got going. He stopped, took off his cap and wiped his brow. He paid no attention to the fact that the first line was getting near the end of the deck, until finally a cockney said:

"Gor' blimey, Guvnor. Aintcha even gonna wave us goodbye?"

(Laughter)

We are not here tonight to wave goodbye but to raise our hands and our hearts in salute to a man of distinction who is still a comer, a man for all seasons.

The presidency has been filled by many men of outstanding character and personality, but never by any man more ebulliently boyish, industriously vigorous, irrepresibly buoyant, or dashingly debonair than Lou Collins. (Applause) It has been a joy to be working with him throughout the year.

And what is true of Lou is equally true of Emmy — the lovely, lively, luscious and ladylike partner to Lou.

As the Irish say: As God made them, He matched them. (Laughter) They complement each other and are as inseparably related as the convex and the concave of a curve.

Of Lou I'm sure Emmy says, "my true love hath my heart and I have his; each to the other given." And for Emmy, Lou's soul-deep song is, I know. "Once in love with 'Emmy,' always in love with 'Emmy'."

May they continue to find joy in each other and give joy to all who know them for many radiant years.

(Applause)

And now, according to the program notes, it is the time for the Immediate Past-President, who is the husband to those two women we spoke about, to induct the next Immediate Past-President — or almost — into the most distinguished and select ranks of the Fellows of The Medical Society of New Jersey.

So I call on Dr. Joseph R. Jehl to present the Fellow's Key to Dr. Collins.

(Applause)

Dr. Joseph R. Jehl: Thank you, Mr. Nevin.

My fellow Fellows, would you please come forward with me? I should like to have your company when I present this key to Dr. Collins. It is my privilege but it is your right to confer it and I ask your cooperation. Please come forward.

Dr. Collins: That gang?

(Laughter)

Dr. Jehl: Never mind. You'll get old some day, too.

(Laughter)

Dr. Jehl: Lou, as I said before, it is my privilege to give you this Key, but it is the right of my Fellows and my brothers who stand before us to confer this honor. You have earned it. You have worked hard, I feel I worked like a son-of-a-gun but you worked — never mind; I'm trying to be polite—but you worked so much harder that I can't see how you ever did it. When I checked your agenda against mine, I sighed a sigh of relief. Thank God I was President in 1966-67 instead of 1967-68.

Lou, I welcome you into the ranks of our Society. This is an honored and a very select group. I know that you will not disgrace us in any way. I know we will be proud of you. But I'd like these Fellows here to say welcome aboard with me.

(Applause)

Dr. Collins: All I can say is thank you very much, Joe and gentlemen. I can never compare to John Bedrick with his Manila shirt.

Thank you very much, Joe.

(Applause)

The Toastmaster: Just to prove how limber the President is, no sooner has he seated him-

self than we call upon him to rise. He will now present the Fellowette's Pin to Mrs. David E. Zuckerman, President of the Woman's Auxiliary, and to welcome her into the peaceful Elysium of retired presidents.

(Applause)

Dr. Collins: Richard Nevin always gives me trouble, as you can see.

Before I start my two-hour prepared speech (Laughter), I must say that they are running this Society wrongly, because the President of the Auxiliary and the President of The Medical Society very seldom see each other during the year, and you can see what I have missed. (Laughter and applause) We met more often in foreign soil — New York, Pennsylvania, and other states — than we did in New Jersey. Now, I don't know what John and Eva are going to do next year. They are going to have a hell of a time, I'm telling you that.

(Laughter)

Now, this is a great pleasure and I know it is a symbol of esteem and admiration of the Woman's Auxiliary and also of The Medical Society of New Jersey. Mrs. Olive Zuckerman, you have worked hard and you deserve this and you are not going to retire, as Dick said; you're going to keep on working for our most worthy Auxiliary. And thank you for a job well done.

(Applause)

Mrs. Zuckerman: Thank you, Dr. Collins.

If gratitude is the memory of the heart, then I ask you please to accept my thoughts for thanks. I have no words.

(Applause)

The Toastmaster: Now, ladies and gentlemen, we come to the principal speaker—the Honorable John E. Hunt, member of the United States Congress from the First Congressional District of New Jersey.

By way of introduction, if any is needed, I should like to tell you that Congressman Hunt was born in Lambertville, New Jersey, is a former Sheriff of Gloucester County, a former New Jersey State Senator from Gloucester, distinguished airman veteran of military service, holder of numerous decorations and citations for distinguished service, outstanding member of Congress, and friend to the profession of medicine and the people whom we both serve.

It is my pleasure to introduce Congressman Hunt who will speak to us on "Apathetic Attitudes."

(Standing ovation)

Congressman John E. Hunt: Thank you, Mr. Toastmaster.

Members of the Society, your Guests and the Brave Attorneys who Ventured in Here this Evening: I noted one gentleman over here whom I have seen on occasions, who wears a most peculiar garb for evening dress at times.

I note the President of the New Jersey Bar Association is likewise present.

I am most happy to be here this evening with my good friend, Dr. Collins who, as you know, comes from the County of Gloucester, State of New Jersey — a very distinguished and outstanding man.

Having listened to the eloquent euology of the most noted grammarian of the age, Mr. Nevin, I sometimes wonder, Doctor, how you put up with him for the entire year.

(Laughter)

Congressman Hunt: I'm accustomed in the House of Representatives to being a foil from time to time for the Speaker, Mr. McCormick of Massachusetts, perhaps one of the most outstanding ungrammatical gentlemen serving in the House. So I assure you that it is a pleasure, Professor, to come here and listen to you this evening once more.

You are most kind to the Fellows, but to im-

pose the indignity such as the good Doctor did of having my friend, Dr. Collins, stand trial before a tribunal of Fellows is something I have never witnessed before. Yes, this is undoubtedly the first trial by a physicians' "kangaroo" court in the entire country. (Laughter) But you stood up well under it, Doctor.

Not too many years ago I came into this room — and this room incidentally seats 2200 comfortably for dinner — when it was first renovated, with the manager of the establishment, Mr. Ray. It gave me a somewhat nostalgic feeling when I looked out front and saw the ensemble from Gloucester County. I met some old friends whom I haven't seen in many years, like Dr. Garrison whom I left in Italy in 1944 and have not seen since. Then to find that there are actually barristers here who are physicians. I was a little bit dumbfounded.

I have had a very pleasant conversation at the table. They found out I came from Trenton originally, then somebody discovered that I knew Dick Hughes; then somebody wanted my opinion, which I will refrain. But I want to tell you right now, as I said before, Governor Hughes is one of the nicest men I have ever met socially and I'm most happy that he graced your hall and your assembly with his presence. So far as his political philosophy is concerned, we differ. But socially he is a wonderful fellow.

I have worked here in Atlantic City before. In my previous line of business I had been in Atlantic City in 1940 to carry out a very delicate operation, because in those days Atlantic City was noted for entertainment — in various forms. There was a street down here that was well known throughout the entire nation. It housed those persons who made a living by being a lady of the night. My task was to bring a squad of men in here and obtain the evidence and then systematically remove traces and vestiges of the brothels. Well, I brought fifteen men in and we were here almost five weeks. (Laughter) Some of the gentlemen tell me that it was the most pleasurable experience of their lives. (Laughter) — paid for by the government (Laughter) — one that could be referred to as lend-lease. (Laughter) But we did manage to get rid of all the places back in 1940 and many of the persons who were in the business were sent to a federal prison in Atlanta for two to three years.

After I was married in 1946 I decided the following year to bring my wife to Atlantic City. We stayed at the Chalfonte and went out to walk down the boardwalk, and just as we cleared the front entrance on the boardwalk, lo and behold here came a gal who ran "Thousand Michigan," which was one of the higher class places, a five-dollar place. She came along and we came face to face. As we were passing, she looked over at me and she said, "Good morning, John."

(Laughter)

I said, "Good morning, Mary." And for the next fifty feet I can assure you there was dead silence.

(Laughter)

Finally my wife said to me, "How do you know her? I recognized the breed of cat."

"Well," I said, "I know her professionally."

(Laughter)

She said, "I thought so. But tell me, whose profession?"

(Laughter)

So you gentlemen who are in the field of the famous profession of medicine, if you think that from time to time you have to get out of a tight predicament, you should have been with me over that Easter, which wasn't the most jolly phase of my life.

Of course, we from time to time lose track of the fact that in a profession there is a certain amount of jealousy — not in the medical profession — it exists mostly in the banking profession. I come from a banking family originally. I'm the black sheep of the family. I

am still entitled to go in and out of the bank. I serve on several boards of directors. But, you know, we had a little difficulty. The president of our board of directors was taken seriously ill and was in Underwood Hospital. We had a meeting and it became my very happy lot to send some flowers to him with our sincere thanks for his efforts. And then inadvertently, when I wrote the message, I made a slip. I wrote on the message: "Dear So-and-so, we hope that you enjoy the flowers and we members of the board wish you a very speedy recovery. You might like to know that we took a vote on this issue and it was seven to six."

(Laughter)

The papers I have in my hand are not the text of my discussion this evening. This is simply the correspondence that has emanated between my office in Washington, my home in Pitman, Dr. Collins, and several sundry and various secretaries. My secretary said to me today, "Don't forget, you're going to meet Dr. Collins." I said, "Yes, I'm well aware of this."

Every fifteen minutes I got a call from the page boy: "Mrs. Bell says not to forget your plane at 3:50."

Very frankly, I wish I had driven over here because I got on that confounded thing and I have never ridden on a more turbulent roller coaster in my life. I think we came in with the tail down and the nose up. There were about eight or ten on there quite ill. Two men got off at Salisbury; they wouldn't get back on again.

When I came in I thought sure somebody had passed away because there stands this great big black limousine with chauffeur. He said, "Are you Mr. Hunt?" I said, "I am." "I'm supposed to take you to a place where you will meet some friends." I said, "What do you do in your spare time?" He says, "I'm an undertaker."

(Laughter)

Now, this crowd does not appear to me to be that type of a gathering that would play a trick on me, but I'm not so sure, knowing Lou Collins. I'm not so sure when I see a couple of my younger friends from Gloucester County, physicians who from time to time indulge in the gentle art of needling from the ringside.

I do want to talk to you a little bit tonight about the situation that has developed. I have been a firm believer for a number of years that we in this country have become too complacent in our way of life and that from time to time we think that everything will straighten itself out; that it does not require any help from either you or from I, because the I should be me and the me should be you. Grammatically we have to look at this in a different light. We have to remember, as Dizzy Dean said the other night on television, "I should have been walking when I 'slud' into second." And so the apathetic attitude which prevails in this country has now begun to dissipate itself. The attitude of apathy has been all too prevalent. We have become too smug. We have become the people in a fun loving nation. We have become people endowed with multiple riches bestowed upon us by our God, but we have strayed far from the course of what we are supposed to do. From time to time we don't have time; we become too busy. We have time for everything else except to do those things which are so vital to keep this country in the position we have always enjoyed.

For instance, today we find ourselves in perhaps the most severe financial crises, even approaching that of 1929. The stock market is so sensitive that the very fact that some minute discrepancy arises or another nation has a crisis in its cabinet so affects our financial balance today that people panic. We have become a nation of untrusting people. You know that France is in serious condition this evening. They are totally paralyzed by virtue of strikes. The government is in precarious position. The stock market today doesn't look too good again.

In this country alone we stand on the very brink of financial disaster. Whether people want to tell you this or not, the head of the

board of the Federal Reserve told you this a year ago; he told you this six months ago; he told you this three months ago. And yet it seems so very difficult to impress upon the American people and especially among people with whom I am associated every day — those in the political field—that we must tighten our belt and again look to a spending condition conducive to good business ethics. We must begin to listen.

You would be surprised if you knew who wrote to me or called me and day after day simply saying to me: "John, I would like to get X number of dollars for a project." "We would like to do this in a city." "We would like to do this for a sewerage authority." And when I say to them: "Where would you expect us to get the money, what field of taxation do you suggest that we now embrace — of the poor downtrodden person who pays it out by April 15th each year — which field would you expect us now to put the additional bite on? Would it be in the corporate field or would it be in the field of additional income tax, or how would you go about this?" And when you say corporate tax to the businessman, he throws up his hands in horror.

I had the occasion to speak three weeks ago at a closed hearing on finances with one of our better known presidents of a railroad and when I suggested to him additional corporate tax, I thought he was going to have a fit. I said, "Well, don't become excited. I noticed that last year you paid the best dividend that you've paid in twenty-one years, so you are not hurting. And tell me once more, why did you declare your bonuses?" Private enterprise is making money. But they seem to think that Uncle Sam has become a sugar plum tree and that all we do is shake this tree and after all the plums are off that we replenish the tree by virtue of raiding the taxpayers' pocketbook. I want to tell you right now, the end has come — it is in sight. We are 20 billions of dollars in deficit this year and if the spending continues at the rate it is going now, we will be over 42 billions of dollars in the red this time next year.

People have no conception when they talk about raising the debt limit and the debt ceiling. They think that the raising of the debt ceiling simply means that we are giving permission to the Administration to print more money. Actually we are not. Actually what we are doing is giving the Administration permission to borrow from the banking syndicates additional money to run this country at a fixed rate of interest. Our last bonds coming out are now paying six and a quarter and six and three-eighths per cent on the money we are borrowing to run this country because we are $20 billion behind that little black ball.

We have now come to a deficit and a spending ceiling of about 339 billions of dollars. But what you don't know is that the interest rate is consistently rising and as of now, as of this very day and evening, the interest we pay on our debt ceiling, the money we have borrowed to run this country and nation, is over $14½ billion per annum. More than $14½ billions in interest is what we are paying on our current debt ceiling and we can no longer afford some of the luxuries regardless of what people tell you in the sob sister category.

Again the apathetic condition has prevailed until now we come to an alarming state in our nation known as crime in the streets. How can you reconcile yourself to the fact that the crime rate is up 83 per cent since 1960 and the population has only increased 10 per cent? How do you reconcile yourself to this?

We read in the newspapers each day the opinions of the various people who write the columns. Actually we have to understand one thing, too, that what you read in the column is just the opinion of one man. Oft times they are syndicated, they are editorialized and then the whipping boy of all the problems of the nation — when the apathy dies away and indignation rises — the whipping boy of the entire populous becomes the Congress of the United States of America. And I never knew when I went down there that I was going to be associated with so many drunks, unappre-

ciative people, thieves, consorters, and everything else that I have read about in the newspaper in the past year.

The Safe Streets Bill for crime, which we passed in the House of Representatives in 1967, that was sent over to the other august body known as the Senate, was the beginning because immediately they took up the hew and cry: Why doesn't the Congress pass that bill? But they don't tell the Ameircan public that the House passed the bill in 1967. And so I began to read from time to time of this tremendous uproar of people and receive mail from people castigating the members of Congress for something that they haven't done because they themselves do not know the true facts of life.

I want to tell you, the ladies and gentlemen I serve with down there are to me perhaps the most astute and the most dedicated people I have ever run across. You can come down there any night you wish in the Longworth Building, where my office is, and you will find 40 to 50 of the offices open at midnight — men who have their conferences and hearings and work in the morning and go on the floor at noon and meet constituents when they have the opportunity, and go out and get a little bite to eat in the evening and come back to the offices and work again. These are those drunken, maudlin people that you read about in the newspapers, in the columns. These are those people who refuse to pass the laws that would remove the crime from the streets of this country.

We have laws running out of our ears. It is no longer a question as to why they are not enforced. The question now becomes: Who will give the order to enforce it? And who will tell people, truthfully, that we in the Congress have passed these laws and that they are in existence? Even in the state legislatures there are sufficient laws to cope with this. But we have that apathetic attitude of some people who for the very reason of perpetuating themselves in political office do not have the fortitude to stand up and tell the truth.

So help me — it irritates me so badly to find people who try to perpetuate themselves in any political office by not standing up and facing up to the truth because they are afraid that they may lose a few votes. I want to tell you that if this is the attitude we are to exist in, then I know many men and many ladies in the Congress who would rather lose the next election than they would to serve under those conditions. Because when you violate your principles and when you give into intimidation and when you are browbeaten and when columnists can beat you into the ground by virtue, and virtue only, of a slanted editorial, then it is time to strike your colors and go home — either that or go down with your ship.

We have people in this country today who are beginning to rise to the front and beginning to realize that the apathetic attitude that they have exhibited must now go and they must get behind those people who are trying to do a job for them. You are one of those groups. For many, many years the AMA was dormant. Oh sure, you enjoyed your luxuries, you enjoyed your balls and you enjoyed your dinners. But I know many physicians and I met many in my travels. They didn't want to become involved because they might have to declare their politics. Believe me, the political philosophy today of both parties is so close that it's hard to tell one from the other. But the thing is, we have to come to the center and begin to realize the crises that we are facing. We have to realize the financal crisis; we have to face it with the crime in the streets; we have to face it with the truth to the people; and we have to talk to people and find out from people what they are thinking and try to do our best to put things back in proper perspective.

The cities are in horrible shape. But who put them in horribe shape? People in the cities don't realize the tremendous difficulties they are facing today in many respects. It isn't going to be easy and it's not going to be done overnight. Ofttimes my heart goes out to a mayor in a town who becomes elected because I know that he can't fulfill the promises he

made. He expects to do it, he wants to do it, but he is incapable of doing it because the odds are against him when he starts.

It's gong to take us years to get back on the proper course because of the apathetic attitude that has prevailed through the past 20 years and perhaps 30. So when we get to this point, we begin to realize that it will be people such as you, people in The Medical Society of New Jersey and the AMA who must now begin to talk and look at things in their true light.

I have tried consistently to interest people in the business world and professional men to engage in politics, not as a partisan situation but either in the middle or bi-partisan or embracing either philosophy, whichever one they wished, but only to do a good job for their community. And, you know, it's strange. We find more and more of these gentlemen coming up to take their place in the ranks.

I don't know whether you recall this or not, but in 1964 we had an election in this country. A gentleman ran on one ticket, another gentleman ran on another, and all throughout the country the columnists began to write, newspapermen began to write. People voiced their opinions. And a strange thing occurred, something that the American Medical Association was quick to repudiate, something the American Medical Association was ashamed of. A man was polled. They polled one presidential candidate among over 12,000 psychiatrists — over 12,000. The 12,000 psychiatrists who had always exhibited — prior to this — an apathetic attitude had never seen this candidate personally, he had never been their patient, they knew nothing about his family life except what they read and what was spoon fed to them by the news media. Of the twelve thousand some odd hundred psychiatrists, 1189 condemned the man, 658 said he was all right, 571 didn't take any position — 1189 said this man is unfit to be president of the United States of America.

Let me tell you and let me recite to you just a few of the things that they said about him. They said he was a mass murderer. They said he was immature. They said he was a paranoid, was a schizophrenic; that he was a dangerous lunatic; and last but not least, they said he was immoral and they hinted, several of them, in the realm of homosexuality.

If ever there was an indictment, and the indictment was printed in a now defunct magazine known as FACT, edited by a man by the name of Ginsburg — if ever there was an indictment of the American society that was it. Whether you know it or not, this man is currently in court trying to clear his name against the overwhelming odds of a decision rendered by the Supreme Court that simply says that they can say anything they want about any candidate, anyone can say it, or they can print it, regardless of whether it is true or not, unless you, the victim, can prove that it was malicious in thought when they said or printed it. The only persons who are in this category are candidates for public office and people who hold public office, insofar as redress for libel is concerned. If they said it about you and you were not in public office, you would have the best legal suit in the country. If they say it about John Hunt, it's perfectly all right because I'm the one who has to prove that you had malicious thoughts when you said it.

Yet the psychiatrists back in 1964 said all of these things and now the man is trying to clear himself. There was no proof and no psychiatrist has come forward to testify that he ever treated this man or ever had him as a patient. This is the indictment of America.

I'm very happy to tell you, and I was very happy at the time and I have learned more since, that the American Medical Association was incensed about this, and rightly so. I think we have to rise above matters of this nature. I know as professional men that you did not subscribe to it.

So we have the going back and forth of the apathy and the apathetic attitudes but I sim-

ply say to you tonight, ladies and gentlemen, thank God the picture is changing; thank God the apathy is beginning to wash away; and thank God the people are beginning to look at the picture in its true perspective. I certainly hope no one in this group would take too much stock when they read some of the things about the people in Congress. Of course there are no angels running around this room or running around the halls of Congress. This is a known fact. Every crate of eggs has cracked eggs. This is a known fact. But by virtue of association you can't confer and infer that the guilt complex is there. There have been people in Congress of whom I am not proud and there have been physicians of whom you are not proud, but I wouldn't think for one minute that I should castigate the medical profession by virtue of one of your fellows doing something that you didn't believe in.

The problem is the same in every profession. In every professional congregation, in every walk of life we have this. We have those people who unfortunately do something to stigmatize the rest of the unit.

Now, people are beginning to think for themselves. I made 110 trips back to my district to find out what was going on and talk to people because they will talk to me. I'm just one of the common herd and they all talk to me. I'm proud to be in that position. I don't care what their political philosophy is. If they need help, we give it to them and try to get it for them. But the mail has increased tremendously and Mrs. Bell told me this morning — this being a tough day, Monday, that the mail this morning was over 400 letters, answerable — not trash — letters from people who are concerned, concerned with the fiscal responsibility of this nation, concerned with the war, concerned with the bombing pause, concerned with their sons in Vietnam, concerned by the fact that the Viet Cong have now brought into play, whether they want to admit it or not, the most sophisticated of land-based rocketry, concerned with the fact that Saigon is again under attack tonight and that entire blocks are being wiped out systematically by the same type of sophisticated bombs, not from airplanes but from launchers that were used by the Germans in World War II, only more sophisticated; concerned with the crime in the street; concerned with the fact that people have written biased opinions, which they have now caught up to.

The average American citizen is not stupid. The average American person is quite well read and quite well informed. But we have to have people that the American people can look to, to continue our way of life. We need professional people who will stand up and be counted. One of the foremost groups that I know is the American Bar Association who are doing a tremendous job right now. The American Medical Association is beginning to stand up. The manufacturers are beginning to stand up. They must stand up because the people of this country have come to recognize the dangers, the dangerous situation we are now in. I am only hopeful that they will recognize this and that people who are in the field of political realm, who seek to save their own political hide by virtue of more federal spending, will come to the stark realization that we can no longer pay for something because we don't have the money; and until some other way of taxation is devised that is palatable, we shall find ourselves in this predicament. Until we find a way to obtain an honorable peace — I don't mean a dishonorable peace in Vietnam — I mean an honorable peace, anything short of that is a mockery and travesty of justice for those women who have given their sons. So we have to begin to think a little bit more.

Every night when I go to bed I say a little prayer and I simply say good Lord, help me to keep my head and do the very best I can for all the people that I know and represent. Every morning at breakfast my wife does likewise.

I think today we have to begin to realize that if we are to exist as the great nation we are, we must begin to believe that God is still the Master of the universe. But only through the

assistance of people such as you, people in prominence, and you are prominent because you can influence people — you are in that position. The only people that can't influence me are obstetricians because if I have to deal with one more I'll go to Siberia and my wife will go to Ancora. I only say that facetiously because Dr. Fox is my wife's physician and he keeps pretty good track of me, too. He's been trying to entice me in that back room for years but I won't go in there.

You are here to enjoy yourself and I am most privileged to have been able to tell you what I think. I'm very appreciative for your very kind audience. I'm happy to know that you have bestowed upon your people, your officers, an honor they so richly deserve. I'm so very happy to see that you did not close us out, that you have an open mind and invite a few of us people who are not physicians, some who are in the field of barristers, some who are in the field of secretaries, and a fellow like me who used to work for a living and is now engaged in the art of politics. I want to thank you for your very fine reception this evening.

In case you are worried about this rumor on a bill that will take your money out of Social Security and transfer it to the welfare, the story is malicious. It was never printed in LOOK Magazine. The letter that is emanating and being circulated is false and unsigned. It has no bearing. The bill was never passed. The bill never got out of committee, and the one that took its place was the one that gave people in this nation, who are at that golden age, twelve and one-half per cent more money in their Social Security. And that's the truth of the bill. The man they are blaming for being the sponsor of the bill — and this is having widespread circulation — was not the sponsor of the bill. Mr. Frelinghuysen had nothing to do with the bill. The bill was sponsored by Mr. Mills of Arkansas. Totally fabricated lies, misstatement of truth from start to finish. And that's why I say to you the apathetic attitude must go and is going. We intend to try to find out who circulated this because now I find out that people in the schools believe it. A large corporation the other day put it on their bulletin board as a fact, never having checked it out for its authenticity prior to posting it.

Have we become a nation of people that simply believe everything we see and read? Or are we going to be a nation of inquisitive people who will check facts and figures before we destroy the lives of our fellowman? It's up to us to either be gossip carriers, rumor mongers of John Q. Solid Citizen, and I respectfully tell you in finality that we need the help of professional people to dispel this air and you are one of the finest groups that I know.

Thank you so very much.

(Standing ovation)

The Toastmaster: Congressman John, we regret your turbulent journey in, but we are very happy that you arrived. And I am sure I express the sentiments of all when I say we thank you for your enlightening, sobering, and at the same time encouraging presentation. I'm sure we breathe easier to know that there are people of your character and worth in Congress.

And now, ladies and gentlemen, in behalf of all of us, I thank you for your gracious presence. The evening is young, the music is enticing, the scenery inviting, and the company unsurpassed. Enjoy yourselves.

(Applause)

(Concluded at 10:00 p.m.)

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:		
Total Possible—Officers, Fellows, and County Delegates		372
Total Possible of County Delegates	352	100%
Total County Delegates Registered	343	97.4%

Attendance of County Delegates at the House Sessions:		% of Possible	% of Registered
1st Session, 5/18/68	(293)	83.2	85.4
2nd Session, 5/19/68	(330)	93.8	96.2
3rd Session, 5/21/68 A.M.	(301)	85.5	87.8
P.M.	(272)	77.3	79.3
Average for all Sessions	(299)	84.9	87.2

Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	62	70
Bergen	38	38	76
Burlington	8	22	30
Camden	20	37	57
Cape May	2	3	5
Cumberland	5	12	17
Essex	72	127	199
Gloucester	4	22	26
Hudson	27	25	52
Hunterdon	2	2	4
Mercer	24	64	88
Middlesex	18	33	51
Monmouth	18	45	63
Morris	16	26	42
Ocean	6	14	20
Passaic	29	33	62
Salem	3	12	15
Somerset	6	15	21
Sussex	3	2	5
Union	31	43	74
Warren	3	3	6
Fellows and Officers	16	—	16
	359	640	999

Physician Guests	98
Physician Exhibitors	15
TOTAL PHYSICIAN REGISTRATION	1,112
Auxiliary	456
Visitors	444
Exhibitors	276
TOTAL REGISTRATION	2,288

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1968	1,112	1,176	2,288
1967	1,017	1,018	2,035
1966	1,024	1,135	2,159
1965	1,019	1,046	2,155
1964	1,040	966	2,006



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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or the most widespread form of vagiitis the most widely successful therapeutic agent, Flagyl, is clearly indiated.

In trichomonal vaginitis, most physiians have reported a cure-rate of 95 er cent or more with Flagyl when inected male partners are treated conurrently and when treatment is epeated for occasional refractory inections in women.

Among the few patients who do not espond to Flagyl are those who may ot have taken the prescribed dosage nd those who may have been reinected.

This high rate of cure obtained with lagyl is unparalleled. Only systemially active Flagyl reaches the hidden eservoirs of reinfection in male and emale genitourinary tracts.

ndications: Flagyl is indicated only in the reatment of trichomoniasis in both the male nd female.

Contraindications: Pregnancy; disease of the entral nervous system; evidence or history of lood dyscrasia.

Precaution: Complete blood cell counts should e made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

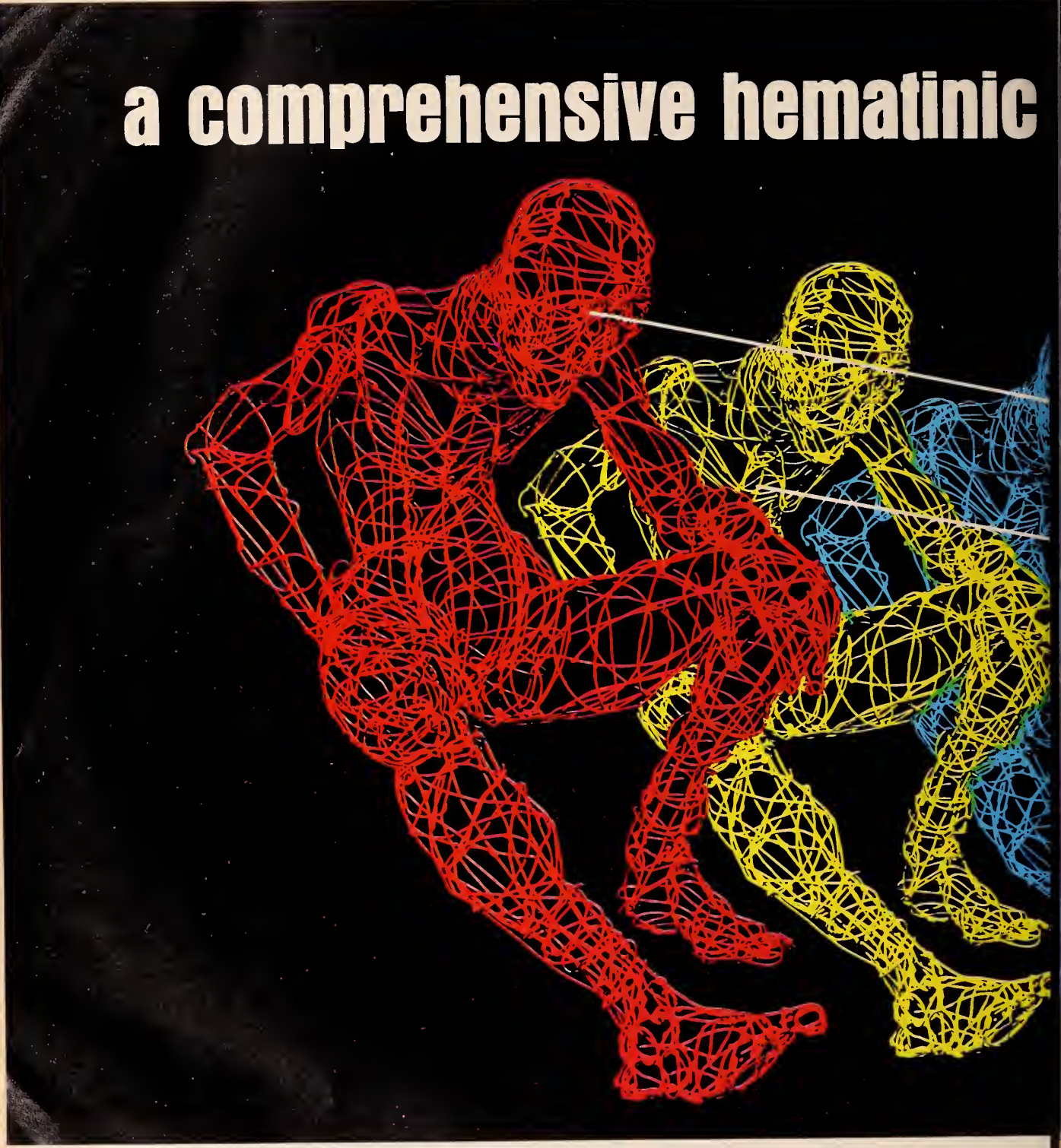
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

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Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

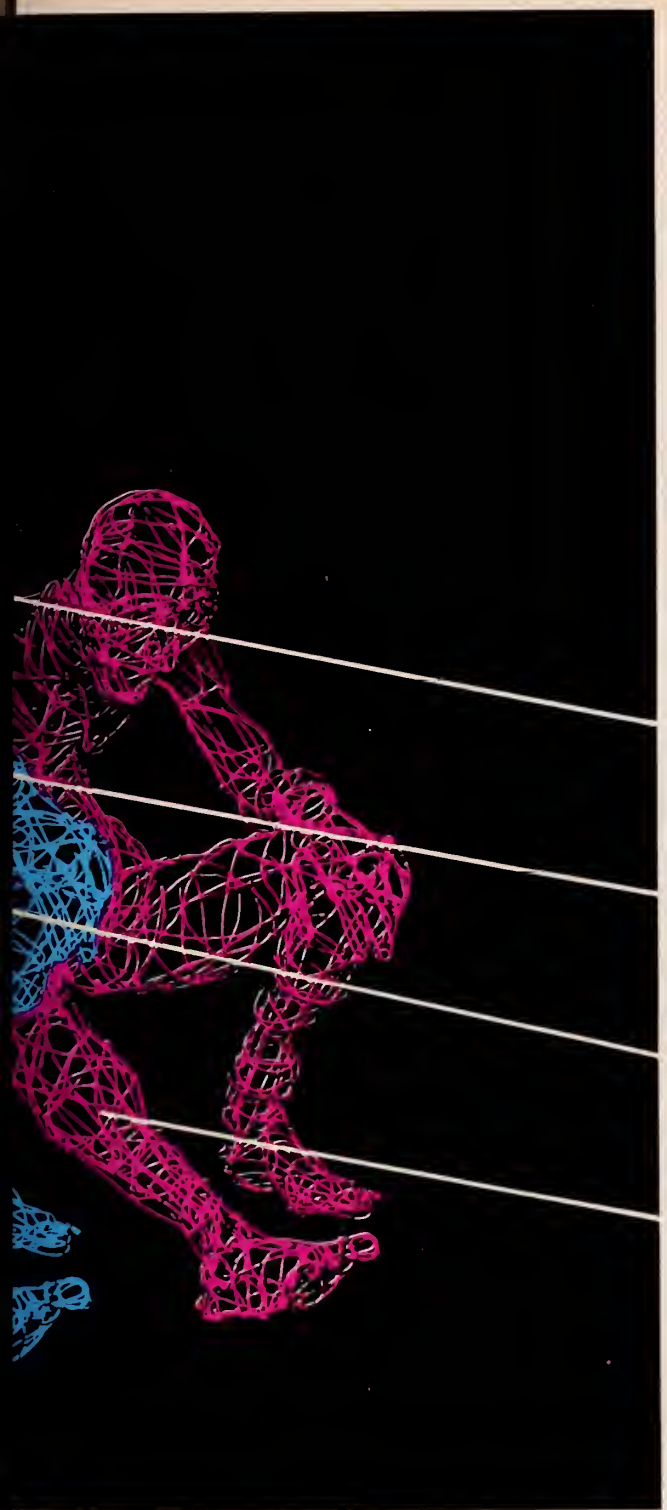
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropr investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adeq vitamin B_{12} therapy may result in hematologic remission but rological progression. Adequate doses of vitamin B_{12} (parent or oral with potent intrinsic factor as in Trinsicon® [hema concentrate with intrinsic factor, Lilly]) usually prevent, hal improve the neurological changes.

As with all preparations containing intrinsic factor, resista may develop in some cases of pernicious anemia to the pote tion of absorption of physiological doses of vitamin B_{12}. If re ance occurs, parenteral therapy, or oral therapy with so-ca massive doses of vitamin B_{12}, may be necessary. No single men fits all cases, and the status of the patient observe follow-up is the final criterion for adequacy of therapy. Peri



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Vitamin B_{12} plus intrinsic factor (15 mcg B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritiona macrocytic anemias and/or malabsorp tion syndromes.

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Iron (110 mg.)—treats hypochromic anemia.

linical and laboratory studies are considered essential and are ecommended.

dverse Reactions: In rare instances, iron in therapeutic doses roduces gastro-intestinal reactions, such as diarrhea or consti- ation. Reducing the dose and administering it with meals will inimize these effects.

In extremely rare instances, skin rash suggesting allergy has llowed oral administration of liver-stomach material. Instances f apparent allergic sensitization have also been reported after ral administration of folic acid.

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"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

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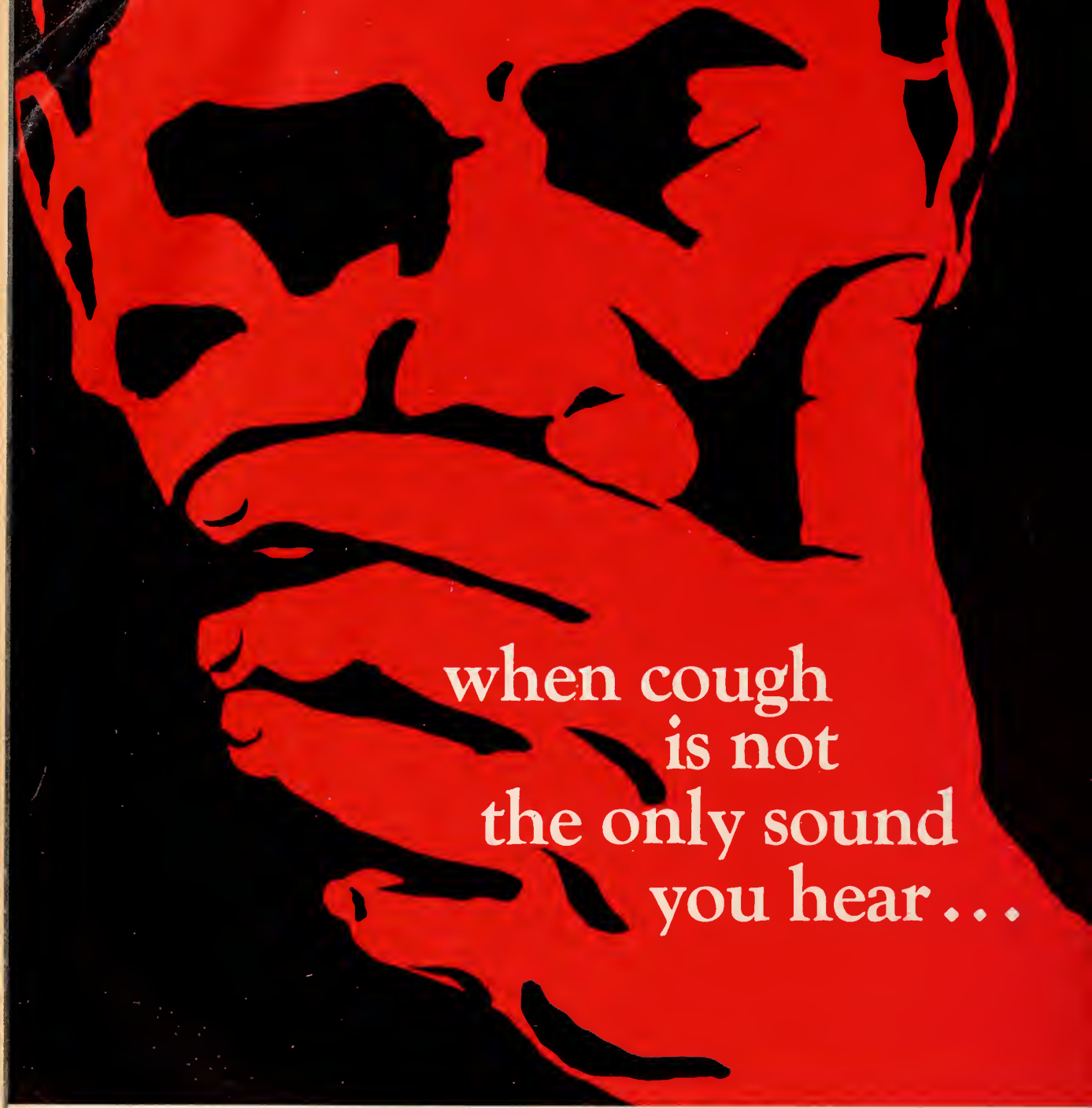
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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

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Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

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Children (6-12 *years*)*:* ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

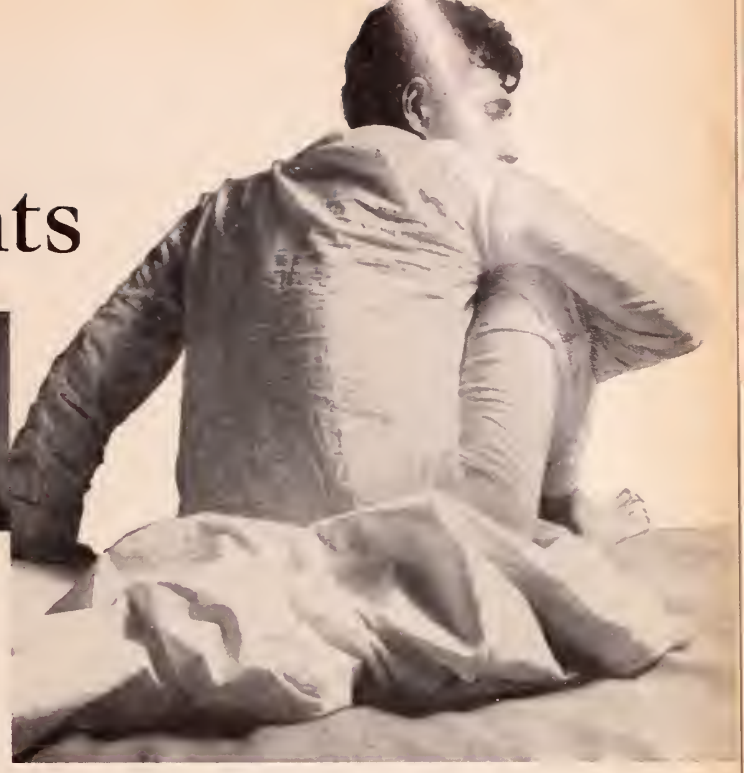
Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

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Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects - particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

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You need more than a pill
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That's why Abbott offers you a pill plus a program.

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DESOXYN® Gradumet®
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For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



B01444

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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A tablet-a-day provides:

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● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

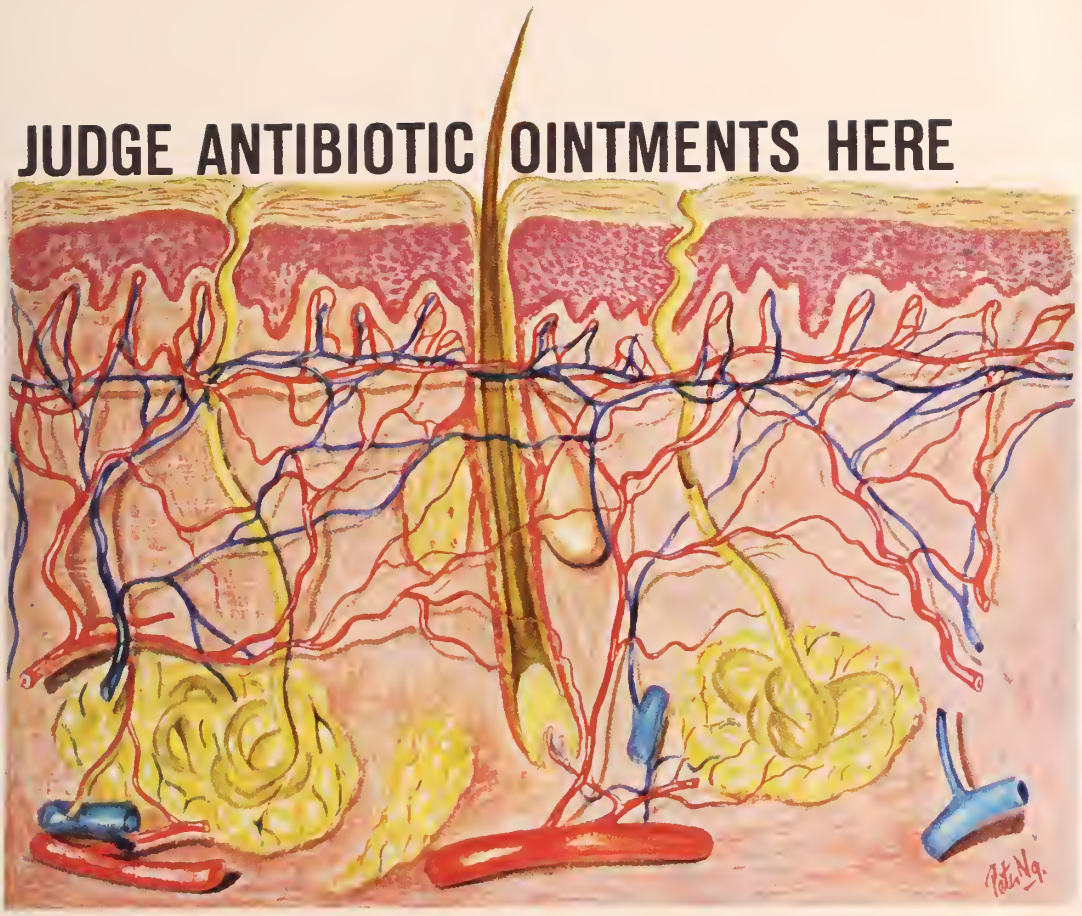
*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

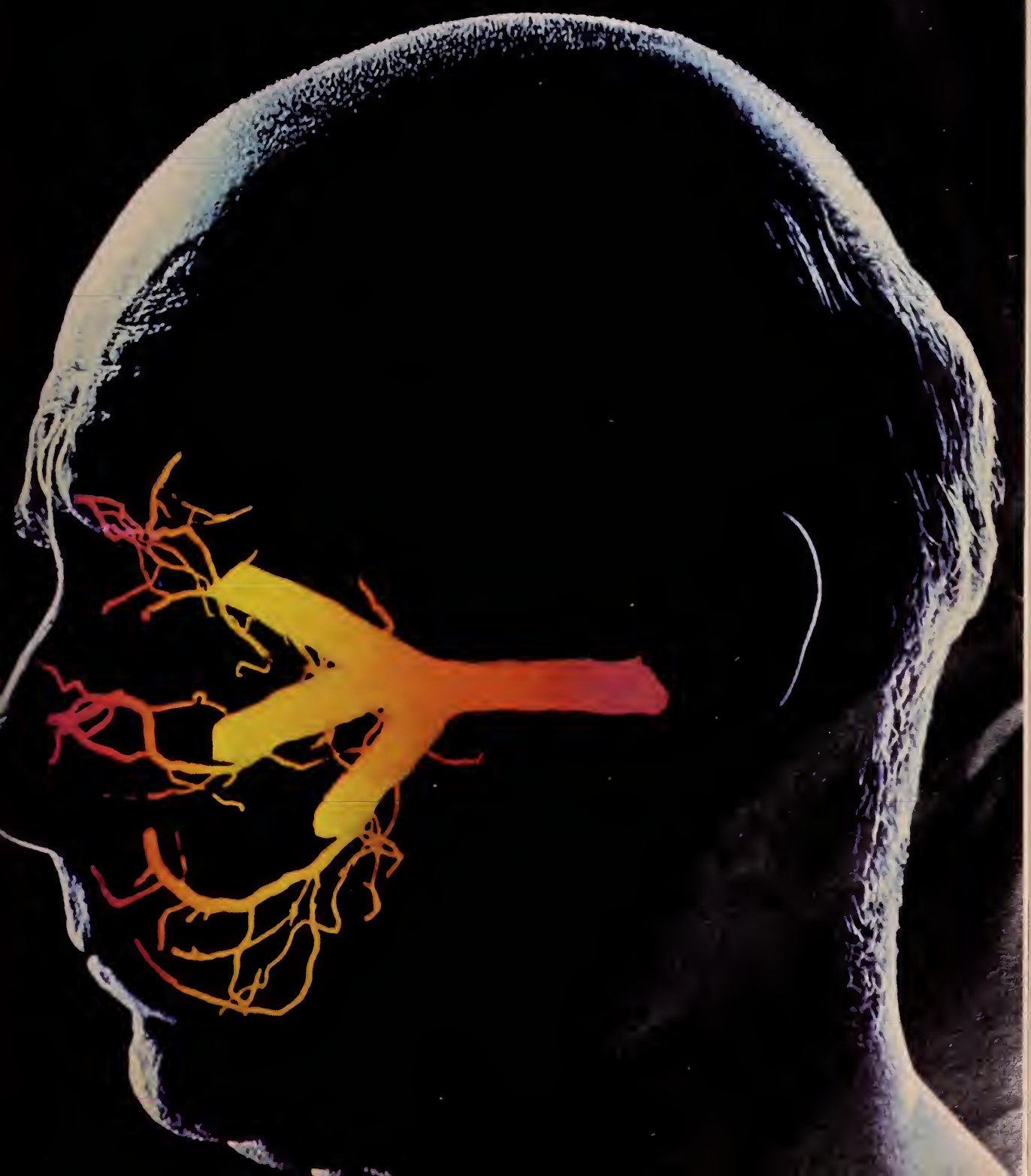
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the d should be discontinued.
2. Liver function tests must be performed at regular intervals during ment with this drug since liver damage may occur during therapy. Th drug should be discontinued immediately in cases of aggravated live dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and ton etry, are recommended for patients being treated with this drug sinc many phenothiazines and related drugs have been shown to cause e changes.
4. Complete urinalysis and BUN should be done on patients treated Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyt eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities liver function tests, cholestatic and hepatocellular jaundice, urinary f quency, acute urinary retention, oliguria with elevated blood pressure albuminuria, glycosuria, elevated BUN, microscopic deposits in the u impotence, disturbances of coordination, confusion, headache, fatigu blurred vision, transient diplopia and oculomotor disturbances, speec disturbances, abnormal involuntary movements, peripheral neuritis a paresthesias, depression with agitation, talkativeness, nystagmus, tin nitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndro photosensitivity reactions, alterations in skin pigmentation, exfoliativ dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, ery multiforme and nodosum, aggravation of disseminated lupus erythem tosus, gastric distress, abdominal pain, diarrhea, constipation, anore dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramp conjunctivitis, left ventricular failure, aggravation of hypertension, hy tension, syncope and collapse, edema, aggravation of coronary arter disease and congestive heart failure. (Whether these cardiovascular are drug-related is not known. However, some of these complication resulted in fatalities.) The necessity for discontinuing the drug shoul dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with m if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the should be increased in one-half tablet (100 mg.) increments every 12 until freedom from pain is achieved. To relieve pain, between 200 m 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patie with a dose of 400 mg. to 800 mg. daily. Maintenance doses may ran between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shou made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottle of 100 and 1000. (B)46-82
For complete details, please see Prescribing Information.

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Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

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lorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R2-46-230-D

For full details, please see the complete prescribing information.

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This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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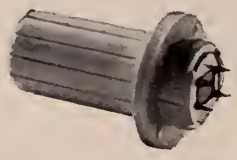
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If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

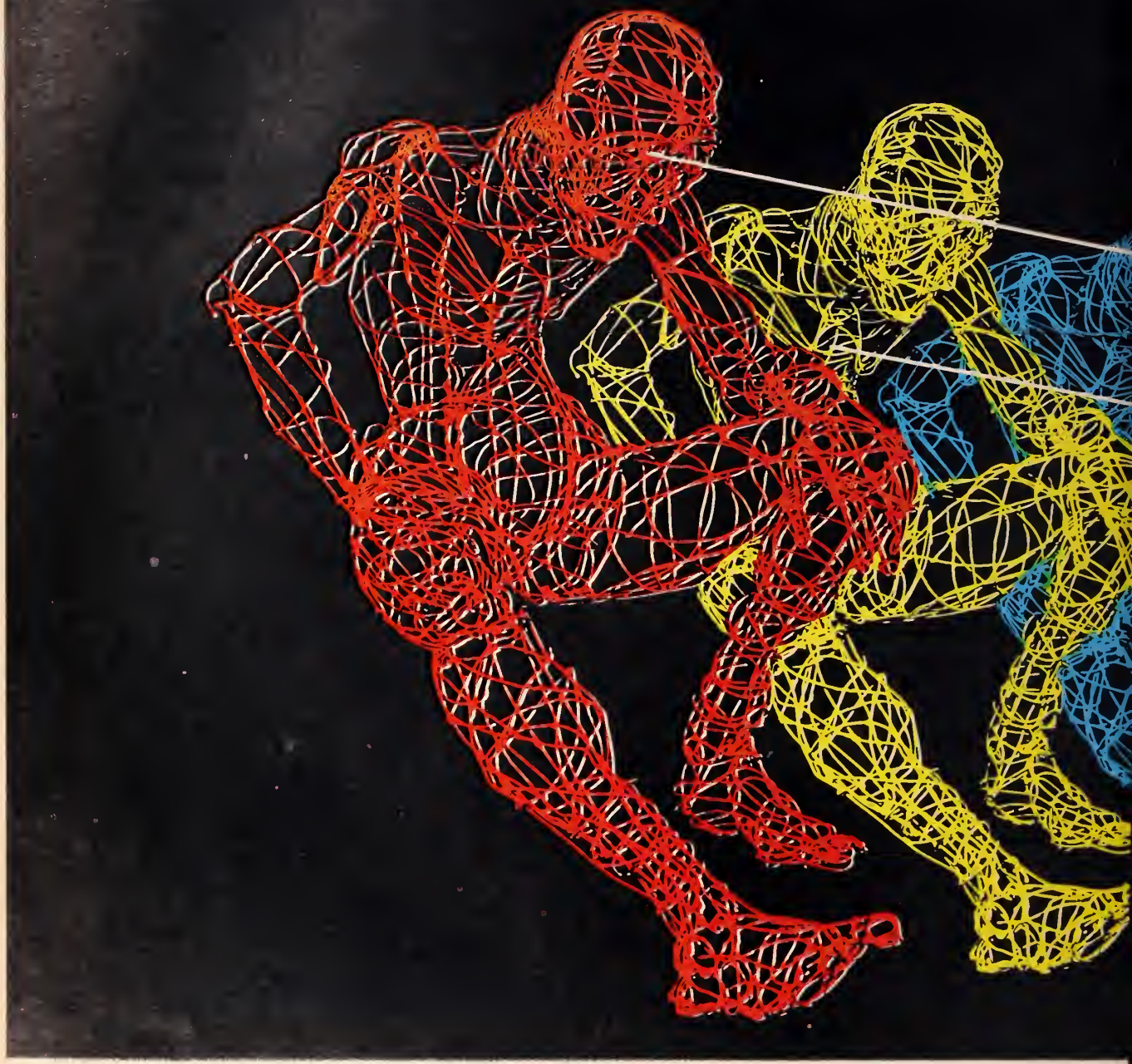
The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appro investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without ade vitamin B_{12} therapy may result in hematologic remission bu rological progression. Adequate doses of vitamin B_{12} (pare or oral with potent Intrinsic factor as in Trinsicon® [hem concentrate with intrinsic factor, Lilly]) usually prevent, h improve the neurological changes.

As with all preparations containing intrinsic factor, resi may develop in some cases of pernicious anemia to the po tion of absorption of physiological doses of vitamin B_{12}. If ance occurs, parenteral therapy, or oral therapy with so- massive doses of vitamin B_{12}, may be necessary. No singl men fits all cases, and the status of the patient obser follow-up is the final criterion for adequacy of therapy. Pe



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

inical and laboratory studies are considered essential and are commended.

dverse Reactions: In rare instances, iron in therapeutic doses roduces gastro-intestinal reactions, such as diarrhea or constiation. Reducing the dose and administering it with meals will inimize these effects.

In extremely rare instances, skin rash suggesting allergy has llowed oral administration of liver-stomach material. Instances apparent allergic sensitization have also been reported after ral administration of folic acid.

osage: One Pulvule twice a day. (Two Pulvules daily produce a tandard response in the average uncomplicated case of pernious anemia.)

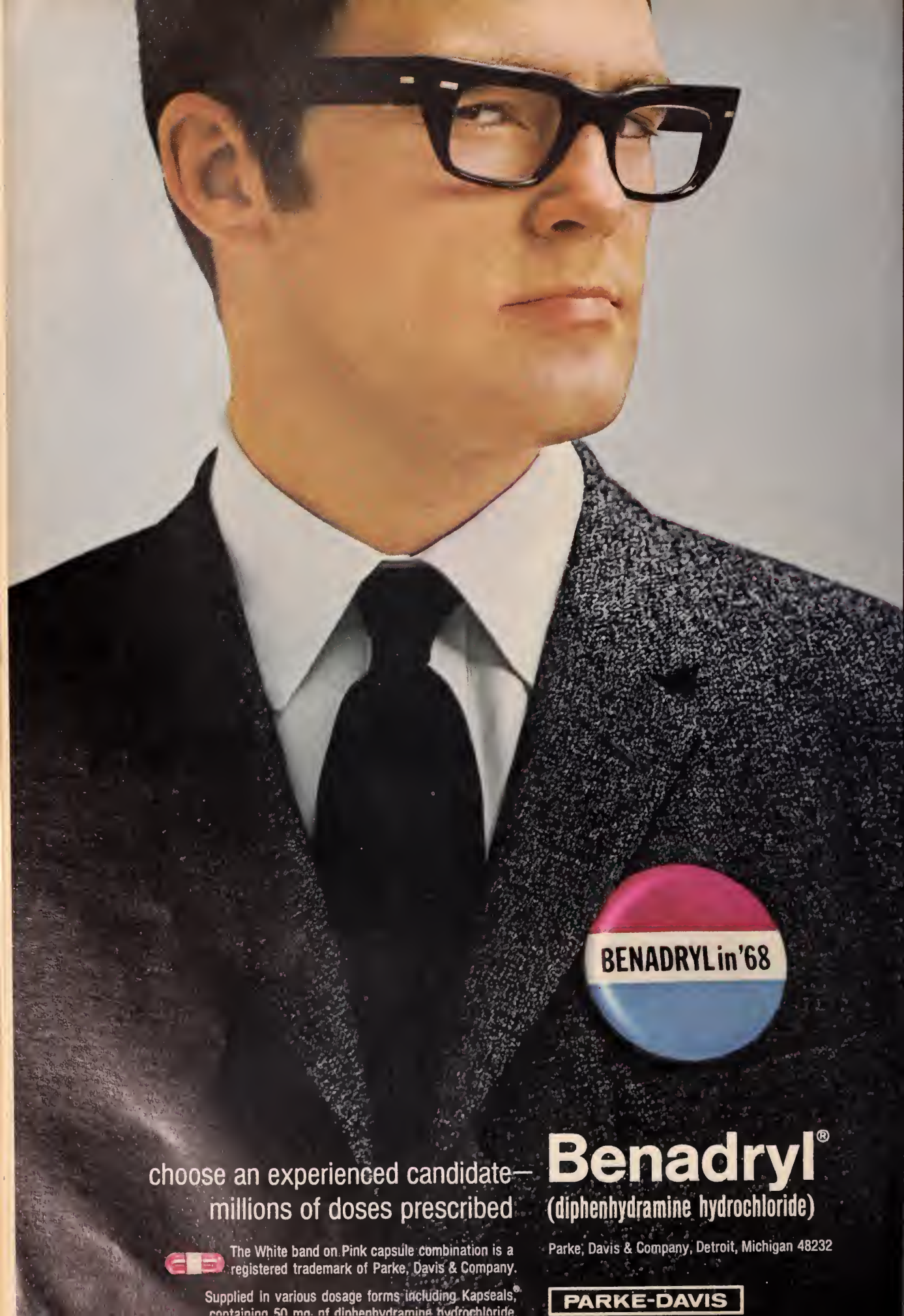
ow Supplied: Pulvules Trinsicon® (hematinic concentrate with ntrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

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Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS



tones down the "explosive gut"

helps restore normal motility and tone

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(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

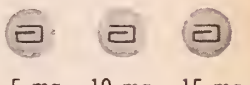
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The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



FRONT SIDE

DESBUTAL 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



FRONT SIDE

The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

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A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*
anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ... 64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL ..... 5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone .... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) .... 10 mg.
Thiamine Hydrochloride .... 10 mg
Glutamic Acid ..... 50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. DOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS. In the female, excessive dosage may produce virilizing effects of most androgens, hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS. See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

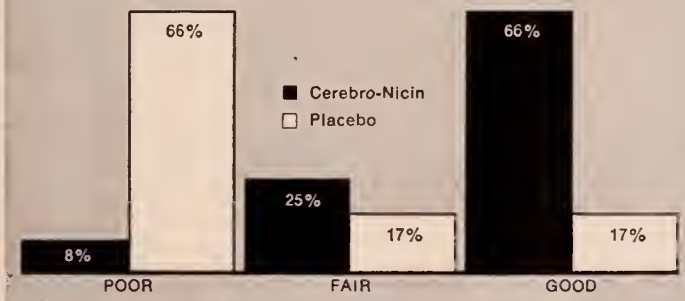
For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient. R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

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Manufacturers of ethical pharmaceuticals since 1856

About that excuse for not wearing your safety belts:

It isn't good enough.

What's your excuse?

Advertising contributed for the public good.



Vacation trip....

Motion sickness?



This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

WILLIAM H. RORER, INC.
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Emetrol®
phosphorated carbohydrate solution
emesis control

When the problem is only skin deep

USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization



Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

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Part of the fine art of medicine



DARVON® COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
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Lilly

60C118

EDITORIALS

There Ought To Be A Law

California, where all kinds of wonderful things happen, recently enacted a law that made quackery a felony. In New Jersey as in most states this is only a misdemeanor. The new statute makes it a felony for "an unlicensed person to purport to treat any ailment under circumstances which cause or create risk of great bodily harm, serious illness or death." The new law stemmed from the now well-known Linda Epping case, in which this 8 year old girl, suffering from embryonal rhabdomyosarcoma, was taken by her parents to a chiropractor who promised relief after noted cancer experts recommended surgery.

The chiropractor treated her for 23 days with high potency vitamins for fees totaling $739. The parents also took the girl to other practitioners but she died three months later.

The district attorney's office charged that the chiropractor fraudulently asserted he could cure the girl. The state alleged that although the girl's case was beyond hope when the chiropractor entered the case, his intervention prevented the surgery that might have prolonged the girl's life.

The chiropractor was found guilty of murder by a superior court jury in 1962, and was sentenced to five years to life. However, the conviction was reversed in 1966.

Apparently to make this a felony, the prosecutor had to do some fancy arguing. He reasoned that (a) getting money under false pretenses is a felony, (b) the death, at that time, resulted from his treatment, and that (c) death following a felony is murder. The California Supreme Court apparently didn't buy this theory, and reversed the conviction.

The statute recently signed by Governor Reagen is an effort to stigmatize action like this as a felony. Under the new law, the State would have to prove ("beyond a reasonable doubt") that the circumstances caused "risk of great bodily harm or death." The operative word is "risk," since to some extent all surgery entails risk. And, of course, one wonders how "great" the bodily harm has to be before it qualifies as such under this statute. The trouble with legislation like this is that any hospital intern (usually *not* licensed) might be branded as a felon if a patient under his care were to die. (Here is an unlicensed person who treated an individual under circumstances which led to his death.) Indeed, the chiropractor would be better protected than the M.D. intern because the chiropractor was licensed and the intern was not.

It is a good illustration of the effort to solve all problems by passing a new law. One result of the legislation is further to emphasize the practitioner's liability for bad results. In this day and age, it may not be a good idea to keep re-emphasizing this kind of liability. We shall watch with interest the actual effects of the new statute.

Medicine's King Sized Award

Giving annual awards — whether cash or Oscars — has been a world-wide habit for a century. Not many of these awards are beamed at medical accomplishments, and most of them are honorary rather than actual stipends. (Pulitzer prizes, for example, do not go above $1000.) So far as is known no annual award in the U.S.A. for medical accomplishments has ever approached the $10,000 prize established by the will of the late Thomas Sheen. New Jersey has a special interest in this, since our own Dr. David B. Allman is one of the two physicians on the award-granting panel. Furthermore, the late Mr. Sheen was an Atlantic City businessman, so our state has a double-barrelled interest here. The Award, in the words of the donor, is to go to

the "outstanding doctor of medical science in the U.S.A. each year."

In the last decade we have had a bad press, and have had to run a gantlet of critics who have laid at the doctor's door a calendar of charges from indifference to greed. So it is nice, for a change, to find some nonphysician who has decided that we also do something to commemorate.

This year's winner was Dr. Irvine H. Page, whose contributions to biochemistry and clinical cardiorenal studies need no further bouquet in these pages. We are sure that equally distinguished practitioners will be the laureates of future Sheen awards. Why hadn't somebody thought of this before?

(More details on the Sheen Award will be found on page 469 of this issue.)

Therapeutic Gullibility

Those of us who have been out of medical school more than 35 years will remember that we were educated during a period of therapeutic nihilism. While we talked about alternatives, febrifuges and stomachics, we did not — most of us — really expect iodides to soften up the sclerosed arteries, nor did we really think that nux vomica was a potent stimulant. In private councils we were willing to concede that I.Q. and S. exercised only a placebo-effect, even though it contained allegedly antianemic and stimulant ingredients. There was an all-pervading aura of skepticism about drugs.

The pendulum began to swing in 1925 when we learned how to crystallize insulin and discovered that it really worked. Two years later came ephedrin, and in 1935 Domagk proved the therapeutic value of Prontosil† and thus opened the door to chemotherapy. In 1938 came Dilantin®. In 1940 the vast usefulness of penicillin was established and the first page of the new book of antibiotics was turned. In 1943 ACTH was developed, and in the following year came streptomycin, number one in the parade of the mycins. The second quarter of this 20th century was an era of wonder drugs. No one knows how many lives have been saved by drugs that no emperor could have commanded when the century was young.

And so therapeutic nihilism came to be replaced by therapeutic optimism. We now call for vitamins, anti-histaminics, tranquilizers, antibiotics, relaxants, and antispasmodics in huge quantities. We place sedatives and stimulants within the same capsule with the hope that they will reinforce instead of neutralize each other. The dazzling patter of the huckster has invaded our medical temples. While we laugh at the extravagance of beer or movie advertising, we often swallow without straining the comparable fantasies of the multi-colored brochure that falls on the desk. It's soothing but potent says one notice. It calms but does not depress says another. No side-effects promises a third. Prevents bleeding by counteracting vascular fragility reads one implausible advertisement. Works synergistically to provide relief from both irritability and torpor. Contains vasoconstrictor, analgesic, and hygroscopic properties. Highly effective with a wide safety margin. Combines stimulant, relaxant, antacid, and vitamin supplement effects. And so on. And on.

No criticism is here intended of the scientists in America's pharmaceutical industry. Humanity owes that industry an unredeemable debt. Our free-enterprise pharmaceutical industry has led to the development of a hundred life-saving, comfort-giving medications. Their scientists work in quiet anonymity to keep burning the Aladdin's lamp of pharmacology. But let it be also recognized that the promoter sometimes pushes aside the pharmaceutical scientist. He, not the scientist, may be getting a free ride on the swinging pendulum.

Has the pendulum gone too far? Has a now discredited therapeutic nihilism been smothered under a naive therapeutic gullibility? A little skepticism may clear a lot of air—much of it hot.

†For the benefit of you young readers, Prontosil was a primitive sulfonamide.

Cardiac monitoring units are not, and should not be the monopoly of research centers or university hospitals. Community hospitals need them too.

Cardiac Monitor Unit

W. Austin Tansey, M.D./Short Hills,
Warren B. Nestler, M.D./Summit
William F. Minogue, M.D./Westfield

At the 1965 Bethesda Conference of the American College of Cardiology, it was the consensus that as many as 45,000 coronary patients will be saved each year, when coronary monitoring units are established throughout the United States. The mortality rate for myocardial infarction has been between 30 and 40 per cent. In those hospitals in which a coronary monitoring unit has been set up, the mortality has been lowered to 20 per cent or below. Hereinafter, the phrase "coronary monitoring unit," will be designated CMU.

This concept was first put into actual practice in Bethany Hospital, Kansas City, under Dr. Hughes Day. By January 1965, there were about twelve such units throughout the country. Today there are about 400 CMU's. But we have some 7000 hospitals in the United States. It seems as if we have arrived at a temporary plateau, with our current 400 units. One prime reason would seem to be that there is a need to train a greater number of physicians in this procedure, so that they could explain to the staffs of their local hospitals the need for a CMU.

We, at Overlook Hospital in Summit, were among the early group, having opened our Unit on April 16, 1965. To provide a formula for other suburban hospitals to set up CMU's, we are outlining our procedure. As our experience with the unit increases, we are altering our emphasis regarding the purpose of the CMU. We have concluded that our main function is to resolve problems of arrhythmia, from whatever cause. Thus, a cardiac problem, without infarction, should be placed in the Unit if the arrhythmia is potentially critical. Conversely, the patient with myocardial infarction, who is in profound shock and in whom prognosis is poor, may have to be referred to the Intensive Care Unit, yielding precedence to the patient with the potentially critical arrhythmia.

Equipment

1. *Beds.* . . . It would seem appropriate to have at least one bed for every 75 beds in the hospital. Thus, a 300 bed hospital should have at least four coronary beds. However, the experience of most hospitals with established units dictates that there "never are sufficient beds" for the purpose.

2. *Environment.* . . . The CMU should be a part of, or adjacent to, the Intensive Care area. There must be no obstruction between the patients' beds and the monitoring nurse; yet each patient should be insured as much privacy as practicable. Hence, glass partitions with draw curtains should be utilized as much as possible. Such items as radios, clocks, televisions, and calendars should be available as medically indicated, since the patient should not be placed in total physical and emotional isolation.

3. *Monitor.* . . . One should be placed on a shelf above each patient's bed. A multi-monitor may be placed near the nurse's desk.

4. *Pulse Meter.* . . . This unit, as part of the monitor apparatus, will automatically provide a signal of an arrhythmia, and high and low rates.

5. *Defibrillator.* . . . Two should be available for each entire CMU, in case one develops a mechanical defect. Each should be placed on

* From the Cardiology Service of Overlook Hospital, Summit, New Jersey.

wheels so that it can be readily moved to the bed-side.

6. *Direct Writing Electrocardiograms.* . . . One such machine with link to each patient would suffice. An auxiliary EKG machine would be available in the adjacent Intensive Care area.

7. *Memory Module.* . . . This device permits the operator to obtain an electrocardiographic tracing prior to onset of "incident." It is highly recommended, but optional. We utilize this module for all of our CMU patients.

8. *Electrodes.* . . . The subcutaneous needle electrode is the most useful, and it minimizes artifacts. Discomfort to the patient is inappreciable.

9. *Alarm System.* . . . A "panic button" should be available which will simultaneously:

a. Alert operator so that she may announce: "Dr. Pacemaker, CMU"

b. Alert nurses in adjacent Intensive Care Area

c. Start time clock

10. *Electrical Facilities.* . . . There should be a minimum of eight electrical outlets per bed; two independent electrical circuits with circuitbreakers; and ground wiring for all electrical equipment.

11. *Ventilatory Devices.* . . . These should consist of Elder demand valve, endotracheal tray, nasal catheters, tracheostomy tray, nasal cannulas.

12. *Bed-board* should be available at every bed.

13. *Suction and Oxygen Equipment and Outlets.*

14. *Drugs* (stock)

Aminophylline — 4 amps.
Aramine® — 4 vials
Atropine — 1 vial
Aqua Mephyton—2 amps.
Calcium Chloride — 3 amps.
Calcium Gluconate — 1 amp.
Cedilandid® — 4 amps.
Dilantin — 4 amps.
Epinephrine (crash cart) 1:10,000
5 vials, 4 in refrigerator
Isuprel® — 10 amps.
Levophed® — 5 amps.
Mercuhydren® — 4 amps.
Quabain® — 2 amps.
Potassium Chloride — 3 amps.
Quinidine Gluconate — 2 vials
Sodium Bicarbonate — 10 vials
Solu cortef® — 3 vials
Procaine Hydrochloride 2 vials, 1 and 2%
Protamine Sulfate 2 vials, refrigerate
Pronestyl® — 4 vials
Xylocaine 2% — 6 vials (lidocaine)

Preparation of Unit

When it is contemplated to set up a CMU, prepare the staff approximately two months in advance. Informative lectures and demonstrations should be provided. Appoint a planning committee. This should consist of physicians, nurses, a nursing educator, the hospital administrator, a hospital architect, and an electrical engineer. The cardiac nurse is the most important individual associated with the unit. Attempt must be made to secure dedicated nurses at least two months before the unit is to open. We have established an intense training course, as outlined below. To staff a two-bed unit, you will need seven trained nurses, with an additional reserve. To protect the Cardiac Nurse in the performance of her duties in this procedure, we have provided a statement which is signed by our cardiologists and placed on bulletin boards in our Unit.

Training Course

Only a limited number of nurses have been trained intensively in cardiovascular disease. Since nurses now form a bulwark of the functioning of a CMU, they will have to be trained for this role. They must be sent for an interval to an established CMU; or a course will have to be provided for them in their own hospital.

Rutgers, The State University, College of Nursing (Continuing Education Program for Nurses) has been funded by the Heart Disease Control Program, USPHS, as one of the twelve national training centers for coronary care nurse preparation. This program was developed in collaboration with, and centered at, the Overlook Hospital in Summit. Small groups of students taking the course receive their clinical experience in the CMU at Monmouth Medical Center, St. Barnabas Medical Center, as well as at the Overlook Hospital in Summit. The curriculum includes the CMU concept, epidemiology, anatomy, physiology, pharmacology, cardiac nursing, electrocardiographic monitoring, cardiac resuscitation procedure, electrical pacing, hypothermia, and psychosocial aspects. Several universities

are now preparing clinical specialists in cardiac nursing. This will provide appropriate background for staffing CMU units.

Organization

The unit is organized and administered by the "Cardiac Resuscitation Committee" composed of cardiologists, vascular surgeons, anesthesiologists, and cardiac nurses. Two specially trained CMU staff nurses must be on duty at all times. There should be one nurse to every 2 or 3 patients. Have the nurses in adjacent areas well trained and prepared to undertake CMU procedure.

Highly motivated Licensed Practical Nurses and nursing aides can be of great assistance. Medical assistants can be trained to record all irregularities through the use of the memory module and bring this to the nurses' attention, as well as to perform secretarial work and errands. Medical social workers have specialized functions which they may perform in the CMU. An electronic technician or an engineer should be available on a full-time basis.

A physician member of the Committee is responsible for the unit for a period of one week on a rotation basis. The duties of the Director of the CMU are:

1. Daily rounds.

2. Review daily the progress of all patients in the Unit, to insure the proper functioning of all policies, equipment, and procedures. In the event that the diagnosis of myocardial infarction is not established, the director will so advise the attending physician and recommend the transfer of the patient out of the Unit.

3. Availability to the nurse for advice on any problem.

4. Provide continuing bed-side education of the nurse.

5. Serve as liaison between the nurse and the attending physician; or when the latter is not available, to take the action dictated by the clinical condition of the patient.

6. Make suggestions to the Cardiac Resuscitation Committee that would improve both the medical and nursing care of the patients.

Admission

Unselective admission to the Unit is dependent upon availability of beds; by any attending physician who has designated his intention of assuming responsibility for emergency procedures performed by the nurse in the Unit. (see below) The patient remains under the care of and is the responsibility of his private (attending, primary) physician. Physicians have been encouraged immediately to admit both proved and "suspect," "good risk," "mild" myocardial infarctions. If no bed is available, the patient may be transferred to the CMU from the general hospital (upon the availability of a bed) within 72 hours of admission to the hospital. Portable monitors are utilized in the general hospital for selected patients. The attending physician signs the following statement:

I hereby request the personnel, doctors and nurses, of the Cardiac Monitoring Unit, to perform their duties, assigned by the Cardiac Monitoring Unit, in the management of any of the cases that I admit to this Unit. I understand that I will continue as primary physician in the case, and will defer to the Cardic Monitoring Unit only when there is a conflict with the established procedure of the unit.

I understand that one or more members of the Cardiac Monitoring Board will make daily rounds in this unit, and that they will not alter my routine orders without discussion with me. I recognize that my patient will not be permitted to remain in this unit more than 72 hours, except for extraordinary circumstances as arranged with the Director of the CMU.

Procedure

Seventy-two hours have been prescribed as the length of stay to accommodate the expected number of patients needing the unit. Those who, after 72 hours, have need of monitoring may remain in the unit at the discretion of the director; or they are transferred to the Intensive Care Unit, where monitors and cardiac nurses are available. If the diagnosis of an acute myocardial infarction is not substantiated, the Director of the CMU will recommend to the attending physician that the patient be transferred to the general hospital.

Consultation is recommended, but not required. The standard or automatic procedures, listed below, require the signature of the attending physician.

1. Bed rest (fed by nurse only if ordered specifically).

2. Critical list.

3. Diet: liquid for 24 hours. Do not administer coffee, ice water, or carbonated beverages.

4. Vital signs every 2 hours. Measure intake and output.

5. Indwelling venous catheter with continuous intravenous of 5 per cent glucose in distilled water.

6. Continuous monitoring of EKG pattern. Record EKG strip every hour and also the appearance of any ectopic rhythm.

7. Laboratory tests: First day — FBS, BUN; Portable x-ray of chest, preferably upright. Daily: EKG, SGOT, LDH, CBS; Prothrombin time is taken if the patient is receiving oral anticoagulants.

8. Oral temperature.

9. Cardioversion by nurse: (a) Ventricular fibrillation (b) Ventricular tachycardia with profound hypotension and stupor approaching coma.

10. Nurse may administer Lidocaine® in accordance with regulations.

At the discretion of the attending physician, the following procedures, or any of them, may be ordered.

1. Narcotics.

2. Sedative or tranquilizer; night sedative.

3. Chair — after 24 hours, for prescribed period.

4. To be fed by nurse.

5. May stand to void with assistance.

6. Commode with assistance.

7. May read or shave.

8. Radio (transistor).

9. Oxygen — mask or catheter.

10. Cholesterol determination and sedimentation rate.

11. Bowel function: no enema first three days. Stool softener (Pericolace,® 2 tablets daily).

12. Anticoagulants: oral anticoagulants and/or Heparin.®

Upon admission of his patient, the attending physician will be presented with listings of the above orders. He will transcribe them onto the order sheet, and not merely request "routine coronary orders."

Nursing procedures upon admission are:

1. Orient and reassure the patient.

2. Check vital signs.

3. Connect the monitor: (a) Needle electrodes #25, 5/8". Male patients should be shaved. Use non-allergic tape. (b) Set high-low heart rate meter.

4. Insert venous catheter (intracath); connect with pediatric drip set containing 5 per cent glucose/water.

Procedure for Cardiac Arrest

A five by eight inch card, one with instructions for Dr. "A" imprinted thereon, and one with Dr. "B" are thrust into the respective doctor's hand by the nurse, as he enters the room. Carry on cardiac compression and artificial ventilation effectively and continuously, with pauses only for such procedure as the use of the defibrillator. The defibrillator will not be effective on a poor myocardium. Oxygenation must be maintained. The amplitude of the fibrillatory wave may be increased by repeated injection of epinephrine. Metabolic acidosis may be forestalled by intravenous injection of sodium bicarbonate every five to ten minutes.

The presentation of cards, Dr. "A," Dr. "B," to the physician as he enters the scene of cardiac arrest, is not an attempt to presume upon his judgment and experience. But rather this is to provide him with a set of established rules in the event that he may deem it expedient to adopt this method. We call "Nurse A" the nurse currently on duty in the unit. Then, Nurse B is the first additional nurse to arrive on scene. Next is Nurse C, the second additional nurse to arrive on scene. Doctor A is the first physician to arrive, and Dr. B is the second physician to arrive. When the procedure is fully under way, there will be the following maximum number of persons in the area with the patient: one anesthesiologist, two physicians, and three nurses.

Nurse A

1. Evaluate: EKG

State of consciousness	Respirations
Skin — cool, sweat	Pulse
Neck veins — distension	Pupil — dilation

2. Pull appropriate curtains

3. Push panic button, connected to telephone switchboard. Operator will announce "Dr. Pacemaker C.C.U." — Button for clock, button for I.C.U.

4. Strike chest several times vigorously with ulnar surface of fist.

5. A. If asystole or profound cardio-vascular collapse: start closed chest massage. (After ventilation — see #6)
B. If Ventricular Fibrillation or tachycardia without pulse: apply defibrillator at once, use foot pedal, 350 watt seconds. Repeat at 10 sec. intervals if needed. Closed chest massage during the intervals.

6. Start artificial ventilation:
   a. Clear airway.
   b. Hyper-extend head. Pull jaw upward and out.
   c. Close nose by pinching.
   d. Three or four huffs into patient's mouth.
   e. Provide continuous ventilation as soon as Nurse B arrives to perform massage, mouth-to-mouth, Hudson Tube, Elder Demand valve.
   f. Defer to Anesthesiologist when he arrives and take on duties of Nurse C, or leave room.

7. If alone, alternate 3 huffs to patient's mouth and 15 compressions of chest.

Nurse B

Cardiac massage:

a. Board under chest — "Rentsch" cardiac press suggested.
b. Heel of hand on lower third of sternum. Other hand superimposed.
c. Sufficient pressure to depress sternum 1½ inches.
d. Rate: 60 times per minute.
e. Check effectiveness by: (1) Femoral and carotid pulsation. (2) Blood pressure — 80-125/systolic. (3) Constriction of pupils.
f. When the physician arrives take on duties of Nurse C, or depart.

Nurse C

1. Make available drugs from the crash cart. Draw up into separate syringes:
   5 cc. — Epinephrine 1:10,000 (crash cart epinehprine)
   10 cc. — Calcium Chloride
   10 cc. — Isuprel® (10 cc = 0.3 mgm.)
   50 cc. — Sodium bicarbonate (50 cc = 3.75 gm = 44.6 mEq)

2. Prepare infusion — 500 cc 5% D/W with 100 mgm. Aramine.

3. Remain available to offer other drugs and equipment.

4. Maintain log.

5. Maintain order. Request individuals, who are not needed, to leave the room.

6. Give cards to Drs. "A" and "B" as they arrive.

Doctor "A"

1. Note interval of time passed since the onset of crisis.

2. Observe that Nurse "A" is properly oxygenating the patient.

3. If asystole:
   a. Take over cardiac masage from Nurse "B," first striking the patient's chest several blows.
   b. If no response from massage, inject 5 cc. crash cart epinephrine into ventricular cavity — 4th or 5th left intercostal space, 3 cm. left of sternal border. Repeat this after 2 minutes. Thence alternate calcium and epinehprine Q 2 minutes, maintaining chest compression between injections.

4. If ventricular fibrillation, give countershock — 350 watt-seconds.

Doctor "B"

1. Take over duties of Nurse A. Defer to anesthesiologist or the inhalation therapist on latter's arrival.

2. Supervise intravenous medications:
   Epinephrine 1:10,000 — 5 cc
   Sodium Bicarbonate 50 cc (3.75 gm) every 5 minutes or —
   Sodium Bicarbonate 5% — as a continuous infusion.

3. If ventricular fibrilation:
   a. If, after 2 or more shocks, there is no response, inject crash cart epinephrine into heart chamber. This may be repeated every two minutes p.r.n.
   b. If ventricular fibrillation does not respond to the above steps, give Lidocaine® intravenously.

The external pacemaker is routinely used by many CMU's for asystole. In our unit, we do not feel that external pacing is practicable.

Post Resuscitative Procedure

When cardiac action has resumed, with a spontaneous blood pressure over 60 millimeters, cardiac compression may be discontinued. Blood pressure may be supported by vasopressors. Respirations should be assisted as long as necessary.

If coma persists, after cardiac restoration, it must be assumed that cerebral hypoxia and edema may be present. Hypothermia should then be instituted, in range of 30 to 32 degrees C.; for 72 to 96 hours. Intravenous urea may be given in doses of 40 Grams in 15 to 20 per cent saline or 5 per cent glucose, providing renal shutdown is not present. An indwelling pacemaker may be indicated to forestall future ventricular standstill. We have a team always alert to perform this function.

Experience in our CMU

Prior to the CMU era, the mortality in accredited hospitals for acute myocardial infarction was variously estimated between 25 and 40 per cent. Since then, hospitals with established CMU have been projecting mortality rates ranging between 11 and 25 per cent. This wide discrepancy is, no doubt, in part related to the fact that uniform criteria have not been established.

To interpret our results at Overlook Hospital, we divided the period, since the open-

ing of our CMU, into two phases. Phase I, April 16, 1965 to May 31, 1966 — this was our "growing pains" interval. Our energies were directed toward the recognition and treatment of cardiac arrest.

Phase II, June 1, 1966 to June 30, 1967, may be considered our interval of "experience." Our emphasis had become directed toward the prevention of cardiac arrest. Lidocaine® and the transvenous pacemaker have been most useful in this regard.

(Table I)

POPULATION
April 16, 1965—June 30, 1967

Cases Admitted	502
Final Diagnosis	
Acute Infarction	231
Possible Infarction	34
Other Diagnosis	237

Analysis of all patients admitted to the unit is outlined in Table I. Diagnostic categories were assigned to each patient following discharge from the hospital, utilizing the criteria set forth in Table II. The category "Other Diagnosis" includes anginal syndrome, arrhythmias, acute cholecystitis, and pulmonary embolism. Of the 502 patients admitted to the unit, 237 (47 per cent) ultimately turned out not to have an acute myocardial infarction. This high figure is a reflection of our policy of immediate admission of "suspect" myocardial infarction. Of the 231 patients with established myocardial infarction, 183 (79 per cent) were admitted to the Hospital within 12 hours of the onset of their symptoms.

(Table II)

CRITERIA FOR DIAGNOSIS

ACUTE MYOCARDIAL INFARCTION

A. TRANSMURAL INFARCTION
- (1) Pain
- (2) Q Waves
- (3) Changing EKG
- (4) Enzyme Rise—SGOT 60
  LDH 1000

B. ACUTE INFARCTION
- (1) Pain
- (2) Changing ST-T
- (3) Enzyme Rise—SGOT 60
  LDH 1000

C. CARDIAC ARREST
Pain or sudden collapse

D. POST MORTEM
Pain or recent infarction at autopsy

POSSIBLE MYOCARDIAL INFARCTION
- (1) Pain
- (2) Non-specific ST-T Changes
- (3) SGOT 35 to 60

OTHER DIAGNOSES

Prior to opening of our CMU, in April 1965, our hospital mortality ranged between 25 and 35 per cent. We were surprised to find that in our first phase our mortality was 24 per cent, in view of the fact that we were extending more meticulous care to the case of acute myocardial infarction, and we had salvaged a number of cases that would have succumbed to an electrical death. (Table III) However, our increased experience is reflected in the 17.5 per cent mortality figure noted for Phase II.

(Table III)

ACUTE MYOCARDIAL INFARCTION

TOTAL CASES	231
SEX	
Male	188
Female	43
AGE	
Range	34 to 89 years
Mean	58 years
MORTALITY	
Phase I	27 (24 per cent)
Phase II	21 (17.5 per cent)
CARDIAC ARREST	
Total	26
Left hospital alive	10
Died in hospital	16

Along with those CMU's that are now well established, we are now projecting our energies towards Phase III. Thus we are attempting, through various media, to educate the community in this subject of acute myocardial infarction, the "number one cause of death." We are training volunteer rescue squads and police in the technic of resuscitation. And we are trying to make the community increasingly aware of the causes of myocardial infarction. Among other tangible benefits of our program over the past three years has been the vast improvement in knowledge and treatment of the coronary victim, not only among our doctors, but also among the nurses and para-medical personnel.

The following case reports represent many similar instances wherein lives were salvaged because of the availability of CMU procedure.

Case One

A 50-year old physician awakened at 4 a.m. with substernal chest pain, radiating to both arms and elbows. He was sweating. He was concerned that he had M.I. He telephoned a colleague who arrived fifteen minutes later. He found the patient pale, sweating, and apprehensive. Pulse was 110. Blood pressure was 160/110. Demerol® 75 mg. was administered *stat.* Electrocardiogram was non-revealing. This patient had been in good health. His last annual physical examination was nine months previous and was entirely normal. He was sent by ambulance to the hospital where he arrived at 5:15 a.m. On admission, blood pressure was still 160/100. He was pale and sweating. His heart rate was 110. There was no murmur, but an atrial gallop was noted when the rate increased. During the fifteen minutes following admission, the following variations of heart rhythm were noted: short run of premature ventricular contractions, followed by a short run of ventricular tachycardia; then a marked bradycardia, a premature ventricular contraction, and then a sinus arrhythmia; then ventricular tachycardia, followed by a brief interval of ventricular fibrillation that reverted spontaneously to sinus rhythm, after that, multi-focal premature ventricular contractions followed.

At 6 a.m., 50 milligrams of Lidocaine® were given intravenously as a bolus. At 6:10 a.m. a bout of ventricular tachycardia ensued, followed by ventricular fibrillation. With the latter, he became comatose and ashen in color. He was defibrillated with one shock of 300 watt seconds, and restored to regular sinus rhythm.

Procaine amide was given as a continuous infusion. During the next several hours, premature ventricular and atrial contractions and brief runs of ventricular tachycardia recurred. At 2:15 p.m. he was switched from procaine amide to Lidocaine.® Multi-focal premature ventricular contractions and short runs of ventricular tachycardia continued, but were spaced further apart. Regular sinus rhythm was established by the next morning.

Electrocardiograms confirmed the presence of an acute antero-septal myocardial infarction. This diagnosis was further supported by other laboratory studies. Thus, his SGOT was 11 units at first and then rose to 140. It fell to 58 the next day and to 29 four days later. His LDH was 295 on the first day, 1300 the next day and fell to 1000 two days later. Sedimentation rate rose from 8 to 32 within 48 hours. WBC was 10,200 on the first day, and fell to 5,300 two days later. Temperature ranged from 99 to 101, and became normal after the fourth day.

He was treated with anti-coagulants and tranquilizers. He was discharged from the hospital on the 38th day. After a routine interval of convalescence at home, he has returned to the practice of medicine.

Case Two

A 62-year old man was awakened at 7 a.m. with a constant retro-sternal chest pain with radiation to the inner aspects of both upper arms. He had been a patient in the CMU only two months previously for observation following a transient episode of anginal syndrome. He was admitted to the CMU at 8:50 a.m. He was pale, apprehensive, perspiring. Blood pressure was 110/85. Pulse was regular at 72. The heart sounds had a soft quality. There were no murmurs or rub. He was subjected to the usual CMU routine. At 3:15 p.m. his pulse rate was 96, rising promptly to 120 on minimal exertion. QRS had widened at 0.20 sec. At 1:30 p.m. on the next day, the heart rate abruptly fell to 60, with frequent premature ventricular contractions. At 5:00 p.m. that day, he started a second degree heart block, with an atrial rate of approximately 150 and a ventricular rate of 50. Two hours later his block became five to one, with brief intervals of third degree block at which time he became ashen, semicomatose and hypotensive. At 8:00 p.m. a transvenous pacemaker was inserted, and his ventricles were paced at 70 per minute with dramatic improvement. At noon the next day, the pacemaker was turned off, and there was no ventricular activity for ten seconds. Within 24 hours thereafter, the patient's sinus rhythm had been restored. The pacemaker was removed eight days later. He continued to make a satisfactory recovery, and was discharged for home convalescence on the 28th day

His electrocardiogram confirmed the diagnosis of acute antero-septal myocardial infarction. This was supported by enzyme studies as follows: His SGOT was 19 units on admission, but rose to 300 the next day, and fell to normal four days later. His LDH was 3,650 units. Sedimentation rate was not abnormal until the third day, when it rose to 75. His leucocyte count was 20,900 on admission and 14,800 two days later. In addition to routine coronary procedures, he was given anticoagulants and received tranquilizers.

Summary

1. Of the 7,000 accredited hospitals in the United States, approximately 400 now have cardiac monitoring units.

2. An outline of a CMU in a suburban hospital has been provided. Included has been a brief description of its personnel, equipment, procedure, and training facilities.

3. Two case reports are provided, to emphasize the value of a CMU.

Acknowledgement

To express our indebtedness to the following would be a gross understatement. They have all played a major role in the development of our cardiac monitoring unit. They should all appear as co-authors of this paper, but for editorial reasons this could not be done. They are Robert E. Heinlein, Director of the Overlook Hospital in Summit; Mrs. Edna W. Dover, R.N., Director of Nursing; Paul K. Boyer, M.D., Chairman, Cardiology Section; Mrs. Jacqueline Buehler, Medical Surgical Supervisor; Kopel Burk, M.D.; Henry A. Connolly, Jr., M.D.; Gerald G. Demarest, M.D.; Mrs. Marguerite Johnson, R.N., Supervisor of Intensive Care Unit; Eugene R. Kelly, M.D.; B. Barry Lupton, M.D.; Adrian Sabety, M.D.; Ralph I. Mond, M.D.; Victor Parsonnet, M.D.; Mrs. Grace Phelan, R.N., In-service Education Supervisor. Many others will have to remain unnamed, although we are well aware of their participation.

85 Woodland Road

Sometimes the "slow-in-school" child has a readily treatable serous otitis media.

Serous Otitis Media*

Harvey P. Yeager, M.D./Irvington

Serous otitis media is a collection of fluid behind the tympanic membrane, filling, to varying degrees, the middle ear cavity. This sterile fluid varies in consistency from thin to thick, glue-like material. It is an extremely common and often undiagnosed problem in children. Armstrong[1] reports that in over a thousand ears with serous otitis media he treated in 2½ years, some 78 per cent were in children under the age of eight.

The common presenting manifestation is hearing loss. This may be an obvious one noticed by the parent or teacher or it may be brought to the parent's attention because the child has failed a school screening hearing test.

There are three basic ways of examining an eardrum. The first is with the standard otoscope. With this, the tympanic membrane may easily be inspected. Gross abnormalities are observed. If the fluid is thin and bubbly this instrument is adequate. It is best to examine the tympanic membrane of a child in the upright position. If there is a small amount of fluid and a child is lying flat, the fluid will spread over the median wall of the middle ear cavity and will not be seen; whereas, in an upright position a fluid level will form. This can be accomplished even in the infant, by having the parent hold the child in his arms.

Air can be gently blown against the tympanic membrane with a pneumatic type of otoscope. When fluid completely fills the middle ear, the drum often looks only slightly dull —and abnormal mobility of the drum is a strong diagnostic sign. Also, on negative pressure, the vessels of the malleus will dilate in the presence of serous otitis media.

The operating microscope is the latest addition to our otolaryngologic armamentarium. With adequate magnification, the drum can be fully examined in detail and careful surgery performed along with adequate aspiration of the middle ear.

In addition to surgery, there are other forms of treatment. The first is inflation of the Eustachian tubes. This can be accomplished with adults or older children without too much difficulty and to a fair degree of success when the fluid is thin and bubbly. However, when the fluid is thick, this is not too successful. In the younger child, this is often a difficult and traumatic experience. Inflation of the Eustachian tube can be done either directly or indirectly. Bouginage of the Eustachian tubes should be mentioned, but only to condemn it. Nasal medication, on a short term limited basis, may be of some use. Radiation therapy may be used in selected cases. We frown on it as a routine procedure.

Eighty per cent of all children who have serous otitis media with hypertrophy of their adenoids and who undergo adenoidectomy and myringotomy (with aspiration of the offending fluid) are, in a sense, cured. But it is not unusual (nor should it be considered abnormal) for a child to get a small amount of fluid when an upper respiratory tract infection is present. This will usually resolve itself when the acute upper respiratory tract infection is controlled. Of the remaining 20 per cent, most will respond to another myringotomy with the insertion of a polyethylene tubular aeration device, and possibly a secondary adenoidectomy. The remaining small proportion of children do not respond

* Read before the Sections on Allergy, Otolaryngology, and Pediatrics, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1968.

to this form of therapy. They need a more permanent device. In our practice we are currently using grommet-shaped Donaldson buttons, which will remain in place for up to one year. The polyethylene tubular device in our hands will extrude in four to eight weeks. We have a group of children in our practice who have buttons inserted in September for school, and have them removed in June so that they can partake in summer activities.

No matter what the etiology of the offending fluid, as long as the fluid is present and a hearing loss is manifested we do not have a socially normal child. The role of the otolaryngologist is to maintain a middle ear free of fluid which, if present, will cause a diminution in hearing. We see too many children who are labeled "slow," who become remarkably bright after offending fluid has been removed from the middle ear cavity.

116 Millburn Avenue

Rehabilitation Of Asthma Patients

A useful training film devoted to rehabilitation of asthma patients has been produced by the National Jewish Hospital and Research Center in Denver. It was made possible through a grant from the U.S. Department of Health, Education and Welfare. Entitled "Jerry," the film centers on the rehabilitation of asthma victims through exercise, occupational therapy, psychological assistance, and social activities, in addition to intensive medical care. It was directed by Martin Nacman, the hospital's Director of Rehabilitation.

All patients seen in the film are chronically ill asthmatics who had not responded to treatment prior to being admitted to National Jewish Hospital. The hospital admits patients who have been treatment failures in their own communities. Patients are treated without charge.

The physical therapy described in the film includes postural drainage, involving the use of various body positions, gravity, percussion and breathing patterns to assist in removing excess mucus from the lungs. Posture exercises also are used, and occasionally a special exercise program is given to a patient who must work off some of his anger.

The hospital's program of exercise for asthma patients, a pioneer effort, includes participation in sports. Shown here is how exercise makes the patient's body more efficient, so that he gets more use from the air he breathes. The physical education program is also beneficial to mental attitudes.

Describing the vocational counseling program, the film narrator states, "The experiences of asthmatics have usually been very limited. They have not come to know the world as it is, nor have they become familiar with their own skills and weaknesses. As a result, they may have aspirations which far exceed their abilities, or they may have no strong interests at all."

The film describes the hospital's workshop program, the patient councils that plan and carry out recreational activities and include a tribunal to deal with rules' infractions, and the teaching program that enables patients to continue their education.

Information on the film's availability may be obtained from the Director of Rehabilitation, National Jewish Research Center, 3800 East Colfax Avenue, Denver, Colorado 80206.

Psychiatry now pervades every aspect of medical practice. It faces exciting challenges every day. Dr. Garber here stimulates our thinking about these.

Today's Challenges In Our Mental Hospitals*

Robert S. Garber, M.D./Belle Mead

If my talk today had a theme, that theme would be humility.

I urge humility in two directions. First in considering the past — because very few of the accomplishments, technics, and ideas of which we are so proud today are really original. Second, I urge humility in the face of the future. The task facing psychiatry and psychiatric hospitals is awe-inspiring. If we're to discharge even a portion of our obligations, we must be alert, inventive, forward-thinking, cooperative. There's no room for even a semblance of arrogance or complacency. I know I'm not espousing an easy cause: as T. S. Eliot wrote: "Humility is the most difficult of all virtues to achieve; nothing dies harder than the desire to think well of oneself."

I am constantly reminded that while our predecessors as physicians may have had rather peculiar ideas as to the *causes* of illness, many of their empirical treatments were sound.

From the beginning of time, man has explained death and disease with invisible spirits. When the gods frowned, reasoned the ancients, man became sick. In classical Greece, for instance, medicine was a function of the temple. The temple at Epidauros had a fine theatre and a stadium: were these the forerunners of the assembly halls and recreational grounds common to today's State Hospitals? Many medical writers of antiquity were no more impressed by vengeful gods and invading spirits than we are today. Some sort of explanation was due to their patients, and in a theological age a theological explanation was most appropriate. Today, we have a scientific age, and, of course — scientific explanations. But the treatment is still empirical. And there's nothing very new about our scientific approach. Listen to this quotation from Hippocrates[1] writing of epilepsy. "The position regarding the so-called sacred disease is as follows. It seems to me to be no more divine and no more sacred than other diseases, but, like other affections, it springs from natural causes . . . those who first connected this illness with demons . . . and described it as sacred seem to me no different from the conjurors, purificators, mountebanks and charlatans of our day, who pretend to great piety and superior knowledge. But such persons are merely concealing, under the cloak of godliness, their perplexity and their inability to afford any assistance."[1]

Soranus, a Greek physician, flourished about 100 A.D. He regarded mental illness in the same light that he regarded physical illness. Only homosexuality was regarded as an illness of the psyche. Soranus treated his patients with isolation, moderate blood-letting, diet, massage — and, rather unusually for his time — psychotherapy.

I've taken my theme of humility to the past partly as a result of reading Bryan's classic, "Administrative Psychiatry."[2] Dr. Bryan's work directed me toward a new perspective on historical psychiatry, and a new humility

* Read by invitation to the Southern Divisional Meeting of the American Psychiatric Association on October 24, 1967.

in the face of our predecessors' accomplishments.

Have we presumed that psychiatric departments in general hospitals are the product of our own generation? Bryan[2] points out that the Hotel Dieu in Paris had two wards for mental patients in 1660. William Tuke who founded the York Retreat in 1796, had developed in-service training programs for attendants, and a system of specialized attendants: "wherein some have ordinary duties and labors of the halls, while others have nothing to do but to accompany the patients and endeavor to amuse and instruct them."[2] Bryan's text was published in 1936. But many of his ideas are as sound today as they were in the '30's. Let me review a few of them:

1. "The administrator," wrote Dr. Bryan, must "maintain a receptive attitude toward the disciplines allied to psychiatry." He argued that a progressive hospital is "one that will be receptive to new thought that is sound; and it will be receptive even to those whose ideas are unusual since psychiatry is in a nascent state. . . ."

2. Dr. Bryan notes that in our eagerness to uncover subconscious conflicts and obscure emotional entanglements, we must not forget that the patient has a body, and that the body may also have an occasional malfunction. Here's another good reason for avoiding rigid compartmentalism in our thinking.

3. Writing of teaching hospitals, Dr. Bryan pointed out that the teaching hospital offers patients better care and has higher scientific standards than hospitals without educational programs.

4. Dr. Bryan wrote that one of the functions of the mental hospital must be psychiatric research. He remarked that erecting more buildings to house more patients offered no real solution to the problem. It is a precursor to the famous phrase of the late, great Dr. William Menninger: "Brains — Not Bricks."

5. Lastly, Dr. Bryan stated that the mental hospital must accept a responsibility for the mental health of the community. Preventive psychiatry, he wrote, offers as much hope for the future as does preventive medicine.

Dr. Bryan offered a statement of purpose for those concerned with mental hospitals. He summarized it briefly: bring about a decrease in the incidence of mental disorders in the community, discharge more patients, decrease the time spent by each patient in the hospital, increase the time spent outside by those who may have to return, and make the hospital a center of activity for all who may have an interest in the mental problems of human beings. The latter, in a sense, was Bryan's own version of the Community Mental Health Center.

Dr. Bryan was willing to implement his generalities with concrete and practical advice. He suggested that hospitals should have personnel officers and tables of organization. He knew that teaching, research, a wide variety of psychiatric thought, and an active medical-surgical service are important factors in creating the professional atmosphere that attracts good staff members.

Today, the prime opportunity is to merge our hospitals and the communities they serve in a way to promote optimum care for the mentally ill. The focus of our attention must be the individual: if he is ill, to make him better. If he isn't ill, to keep him from becoming so. And, to an ever-increasing degree, we must help the individual in the community, using a great variety of technics and resources.

During his presidency of the American Psychiatric Association, Ewalt[3] said:

"I find it hard to believe that a modern community mental health program will fail to find a useful role for the private mental hospitals; but I find it easy to believe that a few directors and boards will insist on maintaining the status quo regarding service and policies, and will thus lead their hospitals into disaster."[3]

Dr. Ewalt then reminded his audience of the fact that few patients are successfully discharged after spending two years in a state hospital.† Some hospitals, tend to become self-perpetuating institutions because of their accumulation of eventual geriatric patients.

Yet, aggressive treatment in British hospitals has reduced the number of long-term schizophrenics from 60 per cent in 1930 to 9 per cent of their census today. To achieve results like these, it is necessary to be responsive to the needs of patients and the resources available. Such leadership entails changing with the times as well as with the needs and expectations of the public.

† Citing a California study.

Perhaps the greatest advance in recent years in mental hospital management has been the realization[4] that the hospital management itself is a factor in the recovery of the patient. Perhaps each psychiatric hospital should be different from all others. The special characteristics of the patients and the special interests of the staff could blend to produce a special flavor and expertise for the institution. For instance, one hospital might be especially well suited to help industrial groups organize programs of preventive psychiatry because of their long experience in caring for mentally ill executives.

The more sensitive the hospital's administration is to the community's needs, the better service it is capable of rendering. A more sophisticated community will accept the hospital more readily. Ideally, such an inter-play of forces should result in a balance that will create a hospital which reflects the social, cultural, economic and political climate of the community. In this connection, Novick[5] has said:

"To this end, the private psychiatric hospital has made significant contributions since it has broken with traditional concepts and rigid approaches to mental illness and treatment of the mentally ill. It has contributed to breaking down the isolation which set the mentally ill in the mental hospital apart from the community.[5]

Dr. Novick then described a professional and public educational program carried out by a public relations expert. The objective was to develop positive attitudes to counteract the emotional stigma which prevents many citizens from participating in community mental health activities. And Tompkins[6] reminds us that:

"An individual community health resource can be evaluated only in terms of its relationship to other health units — public, private, and voluntary. We have learned to look beyond our own activities to determine how best we can relate our actions to those of other facilities. Only by so doing can we and they contribute appropriately and constructively to the total effort to achieve the best possible care for all psychiatric patients. This endeavor must include prevention and rehabilitation as well as definitive treatment for specific conditions."[6]

Proprietary hospitals are, of course, barred from federal grants, but many have made valuable contributions by conducting studies which do not demand extensive funds for laboratory equipment or personnel. It is often possible to borrow facilities from nearby universities or general hospitals. Private contributions — particularly from foundations — are always a possibility. There are more than 6,000 foundations in the United States. And these private foundations give away about $900,000,000 a year, much of it in the health research area. Grinker** has told us that:

"If a private hospital demonstrates that it can do worthwhile research, financial backing becomes readily available." His own experience at Michael Reese Hospital supports his claim.

The National Association of Private Psychiatric Hospitals, collaborating with the National Institute of Mental Health, sent a questionnaire[7] to its membership inquiring about participation in community mental health planning. Almost 80 per cent of the hospitals answering the questions had participated actively in comprehensive planning on state, regional, and local levels. Involvement was greatest on the state level. But many private psychiatric hospitals are involved — in one way or another — in constructing and staffing the new community mental health centers.[7]

One interesting idea is the "unit system." Under this plan, people from the same geographic area are brought into the same part of the hospital. This may mean a mixing of new admissions and long-term hospitalized patients. There are old people who need to be in a medical ward, children who must be educated, and the rapidly shifting alcoholic population. Should all these diverse elements be mixed, just because they all happened to live in the same city or village?[8] Consider, too, that Medicare permits the accreditation of a specific portion of a hospital for the care of the elderly — which means that to get federal money in this area a hospital will probably have to segregate the patients over the age of 65.

How about the challenge of the long-term psychiatric patient? Instead of forgetting the

**Dr. Roy Grinker, Director of Psychiatric Research at Michael Reese Hospital in Chicago.

long-term patient (and allowing him to become a part of the hospital's scenery), one of my colleagues has proposed a continuing policy of evaluation by staff conferences at least once a month on each patient who has been hospitalized for longer than a year. The suggestion is that the conference be held *not* to report progress — since in most cases there isn't any — but rather to examine why the staff has been unable to bring about positive change in the functioning of the patient.

A similar approach to the seclusion or restraint of patients that required the physician who wrote the original order to re-write his order every 12 hours of every day soon reduced the number of hours patients spent in seclusion or restraint. Such a positive approach to the chronic patient might well be just as beneficial.

Ozarin[8] expressed concern about the state hospital evolving into a psychiatric center that is fragmented into many distinct facilities. She wonders how the parts of such a psychiatric center will be put together administratively. And she concludes with the statement, "it will be well to remember that whatever plan is adopted it will not and should not exist forever. There is need to change as new scientific and social advances are made and we must remember always that our goal is to provide mental health services to help those who need them and to promote and maintain mental health."[8]

Emergency service is a relatively new concept in community psychiatry. The Joint Information Service of the APA and the National Association for Mental Health have completed a fine study of available emergency services.[9] They identified 154 facilities that provided such services as emergency care in general hospitals, walk-in clinics, suicide prevention centers, and psychiatric hospitals and clinics. Many of these programs have been financed by a Hospital Improvement Project under a grant from the National Institute of Mental Health.

Many private practice psychiatrists now have patients in a general hospital, use their offices for out-patient services, see emergency patients, supply consultation to other physicians in the community, and make contractural arrangements with community agencies to offer consultation or service to psychiatric patients. There is an interesting side benefit to this shift: the psychiatrist who engages in a varied practice is less liable to see his patient out of context. He views the patient as a part of a community, a group, a family.[10]

If psychiatry is to live up to and meet its challenge, if we are to help those who need help, we must accelerate a trend which I've called "delegation and cooperation."

There are today in the United States only about 17,000 psychiatrists. The number will rise slowly in the years to come, but so will the population. A shortage of psychiatrists is going to be a fact of life for many decades to come. How, then, do we provide individualized care, based on the community, to those who need it? The traditional man-to-man approach just won't work. We must adopt a policy of "delegation and cooperation," which implies that the psychiatrist is the team leader. We will add to that team other appropriate specialists: psychologists, social workers, nurses, vocational rehabilitation experts, as the situation demands. Baron,[10] in this connection, points out that the most important of the new trends is the national effort to plan community programs, and that the planning is a cooperative enterprise between mental health workers and a vast number of other citizens. Indeed, properly guided, these people can do great work. The American Psychiatric Association sponsored remotivation program is one example of this kind of creative delegation and cooperation. In this highly successful program, aides and nurses in psychiatric hospitals carry out a definite therapeutic role.

Industrial therapy — as demonstrated in the CHIRP program — at the Brockton VA Hospital in Massachusetts in another example. Here, under the energetic leadership of a Mr. Frost, patients work at actual jobs at the

going wage, but in the hospital under psychiatric supervision. The program has been a success from all points of view: the patients are helped, and the industries are pleased. As Osler has said: "work is the open sesame to every portal. The great equalizer in the world, the true philosopher's stone which transmutes all the base metal of humanity into gold." Imaginative programs like CHIRP make this vital part of human experience available to the mentally ill, helping them while hospitalized and preparing them, in a meaningful way, for discharge.

Let me read you a quotation from *The Poorhouse Fair*[11] by a brilliant young writer of great sensitivity, John Updike. The novel explores the dehumanizing processes that go on in institutional life. A new superintendent has just come to the institution. Listen to this conversation between the superintendent and one of the old timers in the institution.

"What do you expect at my age? You expect too much from us old people. You expect us to give up the old ways, and make this place a little copy of the world outside. . . . I don't say you don't mean well, but it won't do. We're too old and too mean; we're too tired. Now if you say to me, you must move your belongings over there to that tree, I'll do it, because I have no illusions as to whose mercy we're dependent on."

How tragic that sounds. "We're too old and too mean; we're too tired." It's up to psychiatry and those who run psychiatric hospitals to change this attitude of resignation and acceptance into something vital and realistic.

I'm confident that this challenge — and the other challenges we've discussed today — can be met.

Bibliography

1. Grimm, J. F. C.: *The Works of Hippocrates,* Glogau, 1838. Vol. 2 quoted in Acberknecht, Hafner Publishing Company, New York 1959

2. Bryan, William A.: *Administrative Psychiatry,* Paget Book Company, New York 1958

3. Ewalt, J. R.: *Mental Hospitals,* June 1964 (15:6)

4. Braceland, Francis J.; and Stock, L. P.: *Modern Psychiatry,* Doubleday and Company, New York 1963

5. Novick, R. G.: *Mental Hospitals,* September 1962 (13:9)

6. Tompkins, H. J.: *Mental Hospitals,* September 1962 (13:9)

7. Ozarin, L. D.; Herman, M.; and Osterweil, J.: *Mental Hygiene,* January 1966 (50:1)

8. Ozarin, L. D.: *Mental Hospitals,* 17:9 (1966)

9. *The Psychiatric Emergency,* a publication of The Joint Information Service. American Psychiatric Association, 1966 and The National Association for Mental Health

10. Barton, W. E.: *Hospital and Community Psychiatry,* 17:9 (1966)

11. Updike, John: *The Poorhouse Fair,* New York, 1959, Scribners

The Carrier Clinic

Movie on Medical Careers

Introduced less than two years after its paperback counterpart, "Horizons Unlimited," the AMA's most recent film contribution in the constantly expanding area of health careers, is now available for booking. Created to familiarize young adults with the wide range of rewarding career opportunities in medicine and allied fields and emphasize the ever-increasing need for trained health personnel, it is complimentarily except for postage.

This 16 mm, sound-color production replaces the now-obsolete film, "Helping Hands for Julie." It features approximately 12 specific health career fields and is about 28 minutes in length. School and non-medical groups may secure a print from Modern Talking Pictures, Inc., Prudential Plaza, Chicago, Illinois 60601. Physicians and auxiliary members should write to the AMA Medical Film Section, 535 North Dearborn, Chicago 60610.

The patch test here described is a useful etiologic and differential diagnostic test.

Patch Testing In Industrial Dermatology*

Seymour L. Hanfling, M.D./East Orange
and
Harry C. Goldberg, M.D./Plainfield

The estimated $300,000,000 yearly cost of disability and treatment of industrial dermatoses makes accurate diagnosis and prompt, competent care imperative. The U.S. Public Health Service[1] estimated that one per cent of all industrial workers suffer from some industrial dermatitis at any given time. This means that about 700,000 workers are constantly suffering with skin afflictions due to some contact in their work environment.

Various state labor departments[2,3,4] report that about 65 per cent of all non-accident industrial diseases are dermatologic in character. To emphasize further the importance of accurate diagnosis, experienced industrial dermatologists estimate that 30 to 40 per cent of the cases referred to them as "possibly work-connected" are not. They also state that 80 per cent of the contact dermatoses due to occupational contactants result from exposure to primary irritants, and only 20 per cent from sensitizers. Accurate histories, complete skin examinations, and proper patch test technics are, therefore, of prime importance.

It is here that the *experienced* industrial dermatologist plays his most important role. He must first rule out all skin diseases *not* caused by contact with industrial substances. With the remaining patients, estimated at from 60 to 70 per cent, he must determine which contactant has caused the dermatitis. Although the work history, appearance, and the location of the eruption will suggest the etiologic agent in many cases, it is in the remaining questionable ones that the patch test is of special importance.

To make the diagnosis of an industrial dermatitis simpler, the following criteria may be used.[5] First, the lesions of a contact-type dermatitis must resemble a contact dermatitis. Second, the areas involved must be those that are exposed, although the examiner must recognize that certain areas of exposed skin may escape involvement because of their thickness or toughness. Third, the history of the exposure in relation to onset of the dermatitis often helps. If the patient says another worker has the same rash, take this statement with a grain of salt. Only the presence of several allegedly similar or one verified similar eruption can be acceptable evidence. Last, industrial contact diseases improve when removed from further contact and recur on re-exposure. Persistence of the dermatitis for several months after removal from exposure, despite competent treatment, suggests a non-occupational disease. Some cases defy pin-point diagnosis and, in these patch tests, biopsies, or cultures are done.

The causes of industrial dermatoses include primary irritants and cutaneous sensitizers. A primary irritant is a substance that will cause a dermatitis in about 80 per cent of any average group of normal people on first

*Read before the Section on Dermatology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 21, 1968.

exposure by direct action on intact skin at the site of contact, if allowed to act in adequate concentration for sufficient time. The intensity of the effect varies directly with the concentration of the irritant and the duration of the contact. A *sensitizer,* on the other hand, cannot cause a demonstrable skin change on first contact, but after six or more days may cause changes so that further contact on the same or other locations will cause a dermatitis.

Here patch testing serves as a useful diagnostic adjunct in the work-up of patients suffering from these "possibly work-connected" allergic dermatoses. Patch tests will often pinpoint the guilty or help to exonerate the innocent among the suspected contactants. The preparation and reading of the seemingly simple tests require a high degree of specialized knowledge and experience. Questionnaires sent to ten industrial physicians, who attend many plants, showed that only one does any patch testing and then only on rare occasions. Perhaps the following description of methods and materials will help more industrial physicians do patch testing on more workers.

The patch test is one of the few procedures available in medicine which, at the examiner's discretion, will deliberately reproduce the disease being investigated. It therefore carries a slight but significant danger. The possibility of a flare-up of the existing dermatitis is always present if the guilty contactant is tested. Although the reaction is usually localized to the area of contact, any previously involved or even normal skin may react. This is because the skin is sensitized in its entirety and not just where it is exposed. It is a sensitization reaction of the skin which, in most cases, persists for long periods of time and usually for life.

The patch itself varies according to the tester's preference. It basically consists of the test substance on a piece of gauze, filter paper, or even cotton about ¼ inch square, a ½ inch square piece of plastic or occlusive covering, and a 1 or 1½ inch square of adhesive which will hold the substance in contact with the skin during the test period. The plastic is optional, although serving the dual purpose of protecting the skin from a possibly confusing reaction to the adhesive and also serving to seal in the test substance. The adhesive selected should be one that produces a minimal reaction on the skin and will hold well for 48 hours. The tests may be applied individually by using one of the many commercially available patches.

"Do-it-yourself" fans may cut a strip of their favorite 1½ to 2 inch wide hypo-allergenic adhesive and apply the prepared gauze squares to it in the number required. The tests are applied to either the upper back or the inner aspect of the upper arm. One of us (S.L.H.) personally prefers the back, where there is a greater expanse of skin and where the patient is less tempted to keep peeking under the patches.

For most substances, this is a simple procedure. My only warning is to be sure that the substance tested is not a primary irritant as previously defined. If so, it must be diluted with the proper solvent to a concentration which is no longer a primary irritant but is still strong enough to produce a sensitivity response, if one exists. Schwartz[1] and Fisher,[6] plus many other investigators dealing with reactions in specific industries, list these concentrations and dilutions.

The patient is warned to: (1) Keep the patches dry; (2) Keep them on if they loosen; (3) If any one (or more) begins to itch or burn, to locate it exactly, remove it, and wash the area with water, since this is an acute positive reaction which, if the patch is left on, will result in a severe dermatitis; (4) To return in 48 hours for removal and reading. Upon returning, all the patches are removed, the area is washed gently, and the patient is left for 30 minutes. This gives the skin a chance to recover from any temporary erythema it may develop from the removal of the adhesive or from pressure of the patch itself on the skin. The test areas are then re-examined and read as follows:

o No Reaction.
+Erythema.
++Erythema and papules.
+++Erythema, papules, vesicles, and edema.
++++Bulla formation and edema.

Routine patch testing (described above) will not always serve the purpose. Special situations require additional technics or interpretations.

Children may be expected to react similarly to adults although pre-teens may react with a "false positive" reaction to non-primary irritant chemicals. These "false positive" reactions are usually follicular in character and rapidly fade after removal of the patch.[6]

Atopic individuals react like normal individuals, if the areas of atopic dermatitis are avoided. The special features to be considered in this group of patients, according to Fisher,[6] are as follows:

(1) Pustular reactions develop, especially with nickel sulphate, the halogens, and sodium arsenate.

(2) Non-specific reactions may occur with protein substances such as feathers, silk, and foods, as well as in the tuberculin patch test. These are fine vesicles or occasionally pustules, having little itching or redness, and are localized to the patch test site.

(3) Specific reactions may occur occasionally with protein substances such as molds, feathers, dander, and wool. These are characterized by redness, exudation, crusting, and vesiculation.

The "open" patch test is indicated for use with photosensitizers, volatile substances, strong medications, possible primary irritants, and "when in doubt."

Contact photodermatitis may be classified as phototoxic or photoallergic (with considerable overlapping). Causes of photodermatitis include such well-known drugs as the psoralens, halogenated salicylamides, sun screening agents, chlorpromazine, and various dyes. The test selected attempts to reproduce photodermatitis under controlled conditions. This dermatitis is produced by contact with chemicals which increase the reactivity of the skin to ultraviolet and/or visible light. Various light sources may be used in an attempt to reproduce the photodermatitis. A careful evaluation of both method and results is required for an accurate appraisal of this type of problem.

The presence of a positive or other test reaction must then be interpreted in the light of the work history and physical findings. When they fit together like the pieces of a jig-saw puzzle, we probably have the cause of the dermatitis. We, therefore, see that the conclusions drawn depend upon the knowledge of the physician performing and reading the patch tests.

Summary

The estimated $300,000,000 yearly cost of disability and treatment of industrial dermatologic claims makes accurate diagnosis and prompt, competent care imperative. Industrial dermatoses have been reported by various state labor departments to represent 65 per cent of all the industrial diseases. Experienced industrial dermatologists estimate that only 60 to 70 per cent of the cases referred to them as "possibly work-connected" are compensable. The role of the patch test in the aid of accurate diagnosis is discussed. Patch testing procedures and test result readings are described to enable more physicians to become proficient in this technic. Accurate histories and proper patch test methods are emphasized. The roles of the industrial physician and dermatologist are discussed.

Bibliography

1. Schwartz, L., Tulipan, W., and Peck, S.: *Occupational Diseases of the Skin,* Philadelphia, Lea and Febiger, 1947.

2. State of Wisconsin, Dep't of Industry, Report on

Occupational Diseases, 1966, Stat. Releases 3831; Madison, November 1, 1967.

3. State of Illinois, Dep't of Labor, Div. of Statistics; Report on Compensable Work Injuries, 1964. Chapter 8. Springfield.

4. State of California. Dep't of Public Health, Bur. Occupational Health: Report on Occupational Disease in California, Sacramento, 1965.

5. Birmingham, D. J., and Key, M. M.: Scientific Exhibit, "Diagnosis of Occupational Dermatoses." Annual AMA Meeting, Atlantic City, N. J., June 1963.

6. Fisher, A.: *Contact Dermatitis,* Philadelphia, 1967, Lea & Febiger.

50 South Munn Avenue

The Rarest Of Blood Types

Here at Fort Dix, the dog tag around the young soldier's neck identified him as a blood group O type. He was anything but. Actually he had a blood group so rare that a transfusion with any blood but his own could be fatal. Conversely, a transfusion of his blood into anyone could be equally dangerous. How was this discovered?

A call went out in the camp for blood donations for the Red Cross and the soldier traded a pint for a weekend pass. The blood wound up at Temple University Hospital's blood bank where it was singled out as most unusual. The soldier got a new tag, a new assignment, and information about how risky it would be for him to have or give a transfusion.

Discovery of the error pointed up a weakness in the Army's system of blood typing and led to the proposal by Dr. Molthan† of a precautionary method which would better identify the various blood types of servicemen. He pointed out first "that the military runs up to a 10 per cent estimate of error in blood grouping." Corpsmen have been known to perform blood-grouping tests in hurried cook book style." Dr. Molthan suggested the testing of drawn blood serum against red cells of known blood types to rule out dangerous antibodies.

In the case of this soldier, his blood reacted as a weak group A when tested at Temple. Further investigation identified it as a type of "Bombay blood," which is itself rare. Actually it was even more uncommon, an Ah type, found in only one person before — a Czechoslovak nurse in 1961. Samples of the rare blood were sent to three well-known immuno-hematologists — two in Great Britain and one in American — for confirmation of the blood type identification. Dr. Molthan then enlisted the services of the blood bank at Massachusetts General Hospital to draw blood from the soldier's family. The samples were sent to Temple where the blood of a 14-year-old sister also was identified as Ah.

In the meantime, however, this soldier is stockpiling his own blood at the frozen blood bank at Chelsea Naval Hospital, Chelsea, Massachusetts, in the event of an emergency. The sister will have to wait until she is 18 before starting to bank blood on her own behalf. Can either donate for the other? Different Rh factors complicate the matter. They can, however, receive donations of the less rare Bombay blood which has been identified in 30 individuals throughout the entire world.

If the law permitted under-age persons to donate blood, she could donate for her brother. But a transfusion of his blood into her would cause difficulties. He is Rh positive and positive blood should not be given to negative persons — the classification of the girl. Both the soldier and his sister are registered in the rare donor file of the American Association of Blood Banks.

† Dr. Lyndall Molthan is director of the blood bank at the Temple University Hospital.

An analysis of 50,000 private cases is an unusual review, and this survey suggests many things to the general practitioner.

Office Diagnosis Of Ano-Rectal Complaints

George E. Staehle, M.D./South Orange

Accurate diagnosis is essential for intelligent treatment. This is particularly true of the ano-rectal area. Over the years, diagnosis in this neglected segment of our anatomy, has been a nebulous affair in the minds of many physicians. Hence, this report, which I hope will help to clarify diagnosis and thereby lead to better treatment. The tabulations here are all derived from one source: the combined offices of my father and colleague, Richard H. Staehle, M.D. and myself. This covers a quarter of a century — and almost 50,000 patients.

The diagnoses listed are those made upon *initial* office visit (excepting upper bowel pathology). These diagnoses are *primary,* meaning that (although other minor conditions may have been present at the time) these were asymptomatic and/or did not require treatment. The greater number of patients were patient-referrals from within about a hundred mile radius and sometimes beyond. Fewer than 50 per cent of the conditions involved the rectum *per se,* but were instead related to the anal and peri-anal area.

No attempt will be made to discuss treatment except to state that, with the exception of upper bowel pathology and all cases of carcinoma, these patients were treated in the office, including necessary surgery under local anesthesia.

Internal Hemorrhoids

As seen in Table I, the most common rectal condition (40 per cent) was internal hemorrhoids. The peak age was between 40 and 50. Initial onset was uncommon under 20 or above 70 years. Internal hemorrhoids involve the *mucosal* area just above the ano-rectal line. The mucosa is redundant and excessively vascular. If sufficiently redundant, it will prolapse through the anal canal during a bowel movement and/or during physical exertion. In chronic cases, the protrusion may be constant, causing blood or moisture to soil the undergarments. Thus, the two prime symptoms are bleeding and/or protruding. The blood is *bright* red and is seen either on the toilet paper; or to flow freely into the water. Internal hemorrhoids, *per se,* are not painful. Pruritis and burning involves the anal canal or perianal skin. Even when hemorrhoids become complicated by strangulation, it is the secondary thrombosis and edema of the skin that causes the pain.

Fissure in Ano

The second most common (20 per cent) condition was anal fissure or ulcer. Fissure is simply a tear in the skin of the anal canal. It is precipitated by an abnormal bowel movement or foreign body within the stool. It may even be caused by a physician's rough or careless digital examination or prostatic massage. Fissures not healing spontaneously (or with conservative management) in a week or so, usually form an ulcer and are likely to become chronic.

Symptoms of a fissure are most often painful, burning, throbbing, pressure (from sphincter spasm), and usually blood on the toilet paper. There may be one or all of these symptoms. Ulcer symptoms are similar, but more severe and of longer duration.

The patient with either of these conditions is a very apprehensive one. Diagnosis should be made by inspection, not digital manipulation.

Anal Hematoma

Here is a *common* condition rarely referred to as such, but labelled with such misnomers as "thrombosed external hemorrhoid." This is a simple and self-limited condition. Too often, the patient is shipped off to an overcrowded hospital for an unnecessary hemorrhoidectomy.

An anal hematoma is simply a rupture of one or more peri-anal veins, with resultant distention of the skin by extravasation and clotting. It is a distinct entity, more often than not, associated with a normal rectum. Symptoms are steady protruding, with pain or discomfort and no bleeding. (Bleeding may occur within a few days spontaneously from necrosis of the overlying skin). These symptoms are completely the opposite of those for internal hemorrhoids. Also, onset is sudden; for hemorrhoids, very slowly over a period of months or years. The patient may experience a hematoma several times a year or once in a lifetime. He is *asymptomatic* between the attacks.

Hematomae usually result from abnormal bowel movement, prolonged standing or sitting, or vigorous coughing. If the clot is small, it resolves in a few days. (No wonder so many cases of painful 'piles' are miraculously cured by patent medicines!) If large or if multiple thromboses occur, the condition may persist for weeks if unattended, although the pain usually subsides within a few days.

Diagnosis can usually be made prior to examination by history alone. Inspection will reveal the bluish, perianal swelling, covered with skin, not mucous membrane. The area will be extremely sensitive to pressure.

Fistula in Ano

The acute stage of the fistula is the abscess formation. This will often have ruptured spontaneously prior to the patient's consulting the physician. The location of the abscess (whether peri-anal or peri-rectal) denotes the type or intensity of the pain. Peri-anal abscess involves induration and edema of the external area. An ischiorectal abscess may show no evidence of infection by inspection alone. However the patient is usually feverish and complains of constant aching and pressure pain, usually severe. The symptoms may have lasted for from 24 hours to several days.

Diagnosis of a peri-anal abscess is not difficult. Ischiorectal infection can be detected only by digital examination. Beyond the sphincter, the finger will feel the tender and indurated perirectal mass, most commonly in the posterior quadrant. A chronic fistula is either complete or "blind." The complete fistula is easily diagnosed by the external opening, through which a Bowman probe can be directed through to the internal opening (infected crypt). The "blind" fistula is a greatly enlarged infected crypt, easily palpated with the tip of the examining finger and eliciting considerable discomfort. This type of fistula may also develop from undermining of a chronic anal ulcer.

Pruritis is not an uncommon single symptom for a chronic fistula. This is due to the pus drainage and resultant skin irritation. Pressure (from sphincter spasm) is most common

TABLE I

Age In Years	Number of Patients: Internal Hemorrhoids	Anal Fissure or Ulcer	Anal Hematoma	Fistula (acute)	Prolapse (anal)
Under 20	79	282	137	11(4)	22(4)
20–30	1250	1267	928	192(41)	30(39)
30–40	4543	3732	1728	569(89)	41(65)
40–50	5998	2922	1700	821(103)	84(71)
50–60	4572	1646	907	424(66)	135(57)
60–70	2259	544	327	175(14)	124(28)
Over 70	584	120	88	47(8)	141(19)
Totals (%)	19,305(40)*	10,513(21)*	6122(12)*	2564(5)*	860(2)*

*Percent of total patients in this survey.

in the blind internal fistulae.

Prolapse

It may seem arbitrary to differentiate anal prolapse from hemorrhoids; but in my experience, prolapse is a distinct entity. Anal prolapse is the redundancy of the skin lining the anal canal. Under pressure, this prolapses as do hemorrhoids. However, there is no bleeding, *per sē*. It is of considerable annoyance to the patient, none the less, especially when prolapsing during the day's activities. The condition is often aggravated by thrombotic episodes and considerable pain.

TABLE II

Additional Primary Diagnoses, Initial Examination

Dermatomycoses	1358	Proctitis (Colitis)	134 (55)
Peri-anal Abrasions	669	Inflammatory Stric.	177
Post-operative Stricture	583	Polyp (benign)	106
Dermatitis	564	Verucca Accuminata	98
Anal Papilloma	563	Fecal Impaction	94
Carcinoma*	478	Hidradenitis Supp.	47
Cryptitis	331	Foreign Body	25
Papillitis	218	Normal Examination	3641
		(Pilonidal Disease	437)

*See Table III.

Rectal prolapse (proccidentia) is not common. It is encountered in early childhood and more often in later years. Prolapse and soiling are the usual symptoms, rarely bleeding. Diagnosis is made by having the patient strain as during a bowel movement. The greatly redundant mucosa does not have the injected or varicose appearance of hemorrhoids.

Other Diagnoses

Table II lists the additional primary diagnoses. Many of these (exactly half the group) are solely dermatologic.

Anal Papilloma is an enlargement of the anal papilla. When large enough, it will prolapse through the canal during an evacuation. Papillomae are *frequently* misdiagnosed as 'polyps.' However, they are covered with squamous epithelium, and do not bleed. There really should be no confusion.

Papillitis and *cryptitis* are usually found together and, as individual entities, *per sē* are uncommon, Symptoms of the former are usually burning and formication, and the latter usually more intense, with pressure and aching, with radiation into the buttock of the affected side. The discomfort usually comes several hours after an evacuation.

Polyps in the author's experience are uncommon. Polyps accounted for only 0.25 per cent of the patients in this series. The benign adenomatous polyp is usually an early bleeder and can be discovered when quite small, unless neglected by the patient.

Hidradenitis suppurativa is not as rare a disease as generally thought. It is commonly confused with rectal fistulae. However, unlike a fistula, hidradenitis leads to multiple openings and sinuses with considerable undermining of the overlying skin. No tracts lead to the anal area. Differentiation from pilonidal disease must also be kept in mind.

Foreign Bodies are not common, simply because most accidentally swallowed objects will pass through unnoticed. Trouble may be caused by chicken bones, shellfish shells, hairpins and paper clips. These lodge in an anal crypt and can cause agony until removed. They are easily palpated under local anesthesia.

Carcinoma is the most important of all anorectal conditions since it is a killer and it is too often carelessly overlooked until too late. Table III reviews the small series seen, constituting some one per cent of our total group. Two important facts are worthy of emphasis. First, cancer of the rectum is not a disease of old age. It should be looked for in patients under fifty. Second, by far the greater proportion are within reach of the index finger, which too often is not used.

When a patient complains of painless bleeding, he should not be rushed off for a barium enema. A digital examination should be done first, followed by an ano-proctoscopic study. If the blood appears to be dark and coming from above, then do a sigmoidoscopy. Then, if the bleeding is not accounted for, a barium enema should be the next step. Too often, this procedure is done in reverse. A simple thirty second digital will discover most carcinomas.

The bleeding that arises from a rectal carcinoma is almost pathognomonic. It is usually the *only* early symptom. By the time pressure and urgency are present, the tumor has already reached a size to simulate a stool. It has already invaded the muscularis and metastasized, leading to a gloomy prognosis. Unlike hemorrhoidal bleeding (or that from a fissure), the blood from a carcinoma is murky and mixed with the stool. It never flows freely. Once a physician has palpated a rectal carcinoma, he will never confuse it with any other condition. Do not be fooled by a fecal impaction.

Examining the Patient

The anal area is a sensitive segment of our anatomy. Thus, the patient presenting himself for proctologic examination is usually apprehensive, emabrassed, or ashamed. With this in mind, it seems to this author that the only position that is the most comfortable and the least embarassing for the patient is the left Sims position. The assistant (or the patient) retracts the right buttock, and the physician sits comfortably on a stool or chair. All parts of the examination can be carried out, including sigmoidoscopic study, in this manner. Meticulous inspection precedes digital examination. Should a painful fissue be evident, the patient would prefer to be locally anesthetized before proceding. Digital manipulation should always be done with a well-lubricated finger *before* any instrumentation. In this manner, the canal is far better prepared for the scope, which should also be lubricated. These few simple facts cannot be over-emhasized.

As seen in Table II, over 7 per cent of the patients were completely normal, proctologically speaking. A large number had emotional or psychosomatic disorders such as proctalgia, fugax, sphincter spasm, burning, and pruritis. Coccydynia, prostatitis, and various gynecologic conditions may lead the patient to believe he has a rectal problem.

Enlarged skin tags (usually referred to by the patient as "piles") are extremely common. Often they are labelled "external hemorrhoids," but in reality, they have nothing to do with hemorrhoids. Most women have, normally, an anterior tag which is small but may enlarge over the years from repeated pregnancies. Sentinel tags will develop with a chronic fissure. Larger tags will sometimes form after an anal hematoma has resolved spontaneously. No matter what the cause for such a tag (unless it is infected or very large and annoying to the patient) it is best left alone. We are not interested in beautifying the anal area.

TABLE III

Carcinoma

Age and Sex (M/F)

Site	Under 30	30–40	40–50	50–60	60–70	above 70
Anal Canal	0	0	0/2	4/2	6/5	3/9
0–10 cm.	0/1	9/7	17/11	67/33	78/34	66/25
10–20	0	2/1	2/3	7/3	19/4	10/5
20–30	0	0	2/0	5/2	5/1	2/5
above 30*	0	0	2/2	1/1	7/3	6/0
Totals	0/1	11/8	23/17	84/41	114/47	87/44

*Confirmed by barium enema.

In Conclusion

The most important fact that came to light in making this review (a fact I had suspected for many years) was that fewer than half the patients had rectal pathology; but that often the patient seeking help for his self-diagnosed "piles," did indeed have a minor anal or peri-anal condition.

The non-specialist can diagnose ano-rectal disease with a minimum of equipment and time in his own office. However, there is a need for more definitive diagnosis which will result in better and more simplified treatment and a happier patient.

366 South Orange Avenue

Mechanical dialysis will soon earn its keep in the community hospital. As shown here it can, properly used, save lives.

The Present Use Of The Artificial Kidney*

Bernard D. Pinck, M.D./Passaic

Physicians have long sought artificial means to rid the body of accumulated metabolites and toxins in the presence of failure or inadequacy of the normal excretory organs. Purging, phlebotomizing and induced diaphoresis are examples of efforts used in the past. The acquisition of an artificial kidney by the Passaic General Hospital in 1960 added a significant new modality to the inventory of instruments ordinarily available in a community hospital.

The term is a misnomer suggesting, as it does, a substitute "organ." In essence, the machine is a mechanical contrivance intended for extra-corporeal dialysis in blood. The fundamental principle of osmosis prevails whereby passage through a semipermeable membrane of body salts and metabolites maintains chemical homeostasis. Transmission of blood through the artificial kidney causes the escape of elements dangerous to existence and permits the addition of beneficial agents. The technic of mechanical dialysis is not difficult. The distinctive feature of the apparatus is a drum around which are wound dialyzing cellophane tubes and which is immersed in a bath comprising solutions of sodium chloride, sodium bicarbonate, potassium chloride, magnesium chloride, and glucose. One plastic cannula is inserted in an appropriate artery and a second cannula is placed in a vein. Arterial pressure drives the blood to the kidney whence an electric pump further projects it through the semipermeable cellophane tubes which are now submerged in the dialyzing fluid. The bath is maintained at a temperature slightly above normal to promote ion exchange and to return the blood to the patient's vein at a body heat since there is some loss in circuit. The blood traverses the entire length of tubing. Thereby, it is dialyzed and it is propelled through a filter back to the intravenous cannula. The process runs from 6 to 24 hours. The cannulas are then withdrawn and the "run" is completed. Generally, there are bath changes every two hours and an entire treatment of at least 6 hours is anticipated. Some elements (such as non-protein-nitrogen and creatinine) are absent from the bath fluid. These metabolites and others, known or unknown, which are present in abnormal amounts in the blood of the uremic patient diffuse through the cellophane membrane and are removed in the "rinsing fluids." Excesses of potassium, deficits in bicarbonate and, in general, almost any abberations of electrolyte concentration in the plasma are usually improved or corrected.

The first mechanical kidney was introduced in 1912 by Abel, Rowntree, and Turner.[1] Their early machine consisted of collodion membranes and leech anticoagulant. The dynamics of dialysis which have since evolved have required an increased understanding of fluid and electrolyte balance, the development of the newer anticoagulants and the knowledge of the cellophane semipermeable membranes. Heparin is usually the anticoagulant of choice. The cellophane membrane has

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a pore radius similar to the human glomerular capillary. This means that the various blood constituents of molecular size below that of serum albumin will pass through the membrane if there is a gradient across it. The direction of exchange is dependent on this gradient and it permits diffusion to the blood of substances as well as their removal. Artificial kidneys, as presently constructed, have no counterpart to the renal tubules and therefore none of the homeostatic functions of the human kidney tubules.

Over the past decade, specific indications for mechanical dialysis have been established. Experience and improvement have increased the efficacy and diminished the hazards in situations where the kidney should be applied. Artificial dialysis is used in the treatment of a diverse group of diseases that may be divided into four major categories. These are:

1. Acute renal insufficiency

2. Intoxication with dialyzable non-nephrotoxic agents

3. Selective forms of chronic renal disease

4. Special indications comprising such specific situations as intractable uremia overhydration or metabolic coma in patients with either surgically or medically reversible disease.

The indications for dialysis in a specific case cannot be listed succinctly because dialysis is but one of the regimens of therapy. The medical measures to regulate acid-base and fluid balance, to supply calories, and to sustain the cardio-vascular and respiratory function are paramount and complement each other. Not all patients with the diseases listed above require dialysis just as not all peptic ulcers require surgery. In some instances a better understanding and improvement of medical management might seem to lessen the need for dialysis. Closer supervision of medical needs can save the lives of those with milder forms of disease but in prolonging the lives of those with severe disease processes the aid of dialysis will be required more often as indicated by Merrill and should permit a decreasing mortality.

The Passaic General Hospital has used a commercially available disposable twin coil artificial kidney. Since it has already been firmly established that dialysis will reduce morbidity and mortality in renal failures and poisonings due to a variety of causes, the unit has been made available to the needs of neighboring communities. During the five year period starting in 1961, thirty-six patients were dialyzed with a total of 63 runs. The use of the mechanical dialyzer did *not* eliminate the use of peritoneal dialysis in such circumstances where this appeared to be more feasible and directly applicable.

Acute Renal Insufficiency

Acute renal (and presumably reversible) insufficiency is now the classic condition which is benefited by artificial dialysis. Included in this category is renal insufficiency following transfusion incompatibilities, severe trauma, extensive burns, heavy metal intoxication, obstetric catastrophies, and other causes of renal ischemia and tubular necrosis. The primary therapy (no matter what the etiology) remains medical. Conservative measures of therapy have progressed to the point where the mortality in the so called "lower nephron syndrome" has greatly decreased. Nevertheless, there are cases of potentially reversible renal disease in which the removal of large amounts of nitrogenous waste and correction of the electrolyte balance may be life saving. Although there are no absolute criteria or easily applicable formulas to determine the need for dialysis there are available clinical and laboratory guides. The clinical parameters are related primarily to changes in the psycho-biologic system which manifest themselves as increasing irritability and progressive clouding of the sensorium. The laboratory or biochemical indicators are useful collectively rather than individually. A rising serum potassium level of above 7 millequivalents per litre despite adequate exchange resin therapy, a rapidly rising blood urea nitrogen (usually greater than 200 milligrams per cent) and increasing acidosis despite bicarbonate replacement, with the carbon dioxide combining power below 15 millequivalents per litre have been the most useful sign posts. The biochemical and clinical

changes are concurrent in most cases, and appear in cases requiring dialysis despite attempts to correct and compensate for the changes in the physiology during renal insufficiency. Other clinical and laboratory changes associated with acute renal insufficiency include a bleeding diathesis, nausea, occasional ileus, diarrhea, rentention of creatinine, uric acid and phosphates; as well as depression of serum calcium. These, however, are corroborative rather than prime indicators of the necessity for dialysis.

A separate category of acute renal insufficiency is the adult with acute or subacute glomerolonephritis with anuria. In this instance dialysis as well as other medical methods has been uniformly unsuccessful.

Intoxication With Dialyzable Non-Nephrotoxic Agents

A variety of non-nephrotoxic drugs will cross the dialysis membrane. The artificial kidney can, therefore, lower high blood levels resulting from accidental or intentional ingestion of toxic doses of such substances as barbiturates, other soporifics, salicylates, bromides, potassium thiocyanate, and ammonia compounds. In many instances, survival will occur with the usual supportive and corrective measures. However, the need for dialysis increases with an increased dosage of intoxicant. Often even before the blood level can be determined clinically, the patient's ability or inability to maintain respiratory and cardio-vascular function and the clinical changes manifseted over a period of time are sufficient to indicate the need for the mechanical kidney. Not uncommonly, prior to dialysis gastric lavage, vasopressers, respirators, endotracheal tubes, and tracheostomy have been utilized as indicated. Despite these heroic measures there are often patients who are unable to maintain their vital functions and are benefited by dialysis. Some intoxications that are attributable to salicylates and more particularly methyl salicylate require immediate dialysis because of their deleterious effects in relatively small doses.

Chronic Renal Disease

The role of dialysis in chronic renal disease and chronic renal insufficiency is limited at present. The desired goal is rehabilitation of the chronic uremic patient. It is believed that the correction of acidosis and potassium toxicity will be followed by improvement in appetite and general well being. While this benefit is of transitory value in some patients, it has been reported to be prolonged in others. At present, dialysis is usually tried on patients who present an acute history and in whom the possibility of reversibility cannot be excluded. The key to the value of dialysis to chronic renal disease is at present thought to be urinary volume. According to Keleman and Kolff[2] a volume of 15 hundred centimeters in 24 hours must be reached in order to sustain any improvement brought about by dialysis. The role of dialysis in chronic renal disease has increased with the development of external and internal dialysis units and chambers that allow for daily home therapy as well as centers devoted to runs on a weekly or even more frequent basis.

Chronic hemodialysis was impractical until methods were developed to connect and disconnect the arterial and venous circulations of the patient to the artificial kidney without repeated surgical procedures. In 1960, Scribner[3] described a technic for permanent arterial and venous cannulation with plastic materials which permits repeated intermittent hemodialysis. When the arterial cannula and venous cannula are not used to fill and drain the artificial kidney, they are connected with a "shunt" which leaves the patient with an A-V fistula of relatively low flow, functioning outside of the body. These plastic prostheses have made rehabilitation of the patient with chronic uremia possible after all other medical measures have failed.

According to Deane,[4] for the patient with chronic uremia who begins hemodialysis therapy, there is a variable interval before rehabilitation has progressed to the point at which the patient resumes a relatively normal life (with the exception of the treatment periods).

With rehabilitation complete, the patient requires 6 to 14 hours of hemodialysis at least twice weekly for the rest of his life – in order to maintain life.

Special Indications

Of all the special indications for artificial dialysis, acute spontaneous potassium intoxication is the most serious. The most effective method of treatment for this emergency is application of the mechanical kidney. Acute pulmonary edema and overhydration secondary to acute anuria will often respond to dialysis. Occasionally, improvement in serum metabolites and electrolytes may be affected by the kidney in circumstances of bizarre etiology where other measures have failed. It has also been suggested that mechanical dialysis may be of significant help in management of the "hepato-renal crisis." Another specific indication is the preparation of the chronic uremic patient for operation. The trauma of surgery may be accompanied in patients with renal insufficiency by increasing azotemia and debility. The preparation of such patients by the adjustment of existing chemical imbalance *may* facilitate their postoperative course and their tolerance for the operative procedure.

It is the present policy of the Passaic General Hospital that the artificial kidney should be utilized in acute renal failures manifesting an alarming degree of deterioration following a fair trial on conservative management. The decision to perform dialysis is usually made three to eight days from the onset of kidney injury. In the presence of threatened potassium intoxication, its use should not be delayed. Contraindications to the use of the artificial kidney are active hemorrhage from any site; rapidly progressing hypertension; severe diabetes; and such extreme debilitation of the patient as to make the application of the dialytic process a marked hazard.

Case One

A 20 year old male was admitted because of congenital heart disease in March 1961. Open heart surgery was done consisting of closure of an atrial septal defect with anastamosis of the right pulmonary artery and superior vena cava. The patient is reported to have withstood the procedure well, the operation having been of approximately 4 hours duration. During the first 48 post-operative hours it was noted that the urinary output was diminishing and the urine was dark brown with a heavy sediment. Total anuria developed on the third post-operative day and increasing azotemia appeared. The N.P.N. rose rapidly so that on the 4th post-operative day it was 190 milligrams per cent. The creatinine was 8.75 and the CO_2 combining power was 20 millequivalents per litre. The potassium had risen to 5.2. A watery diarrhea and somnolence developed. On the sixth post-operative day the patient appeared markedly lethargic and had been anuric for four days. The N.P.N. had now risen to 220 milligrams per cent. The CO_2 combining power had fallen to 15 millequivalents and the postassium rose to 6.3. The following day, his condition worsened. It was determined that mechanical dialysis was imperative. Accordingly a "run" was carried out and the patient's clinical condition improved. Two more dialyses were performed over the next 6 days. The patient's condition appeared better and diuresis developed 72 hours after the final dialysis. The patient's improvement was progressive and recovery was completed three weeks after the heart operation.

In May 1963 the patient appeared at the hospital for a check-up and appeared to be in excellent condition. Angiocardiography at this time revealed that the anastamosis between the superior vena cava and right pulmonary artery was of excellent size and well functioning. There was no further septal defect. Blood chemistry taken at this time revealed a normal N.P.N., creatinine and electrolyte studies.

Case Two

A 38 year old woman had had a ureteroileosigmoidostomy in 1961 because of marked contraction of the bladder secondary to incapacitating interstitial cystitis. She was admitted to the hospital in May 1963 in uremia. She had bilateral pyelonephritis more severe on the left side. Review of the patient's hospital record indicated a *not* chronic contracting type of pyelonephritis on the left. The kidney had shrunk to half the size that was present two years previously. The N.P.N. was found to be 116 milligrams per cent. Potassium was 6.2 milligrams per cent and the creatinine was 3.8 milligrams per cent. The patient complained of nausea, vomited frequently, and bled easily from the gums and nose. There were irritable twitchings of the extremities and the patient appeared to be markedly somnolent. Her temperature fluctuated betwen 103 and 104 despite the use of extensive biotherapy. Source of greatest infection involved the left pyelonephritic kidney. Her status was so critical that surgery in the presence of the existing uremic state was markedly hazardous. Accordingly, mechanical dialysis was performed with reduction of the patient's N.P.N. to 58 milligrams per cent and the creatinine to 1.2 milligrams per cent. Clinically, she appeared to be much improved and bloody oozing from the gums and nose ceased.

A left nephrectomy was carried out following which the patient made a complete and uneventful recovery. When seen on October 6, 1963, the patient was ready to return to her occupation. The N.P.N. was 46 milligrams per cent; potassium was 3.9 milligrams per cent and creatinine was less than 1 milligram per cent.

Case Three

A 55 year old woman was readmitted to the hospital in August 1963 because of severe left lumbar pain with

nausea, vomiting, and fever. The patient had a stag horn calculus in the left kidney. The right kidney had been removed by nephrectomy 10 years previously because of calculous pyenephrosis.

On admission, she appear to be acutely ill with a temperature of 103. There was marked tenderness over an easily palpable left kidney. Initial blood chemistries revealed an N.P.N. of 172 milligrams per cent, creatinine 6.3 milligrams per cent and a potassium reading of 5.1 millequivalents per litre. The patient was able to pass only 120 cubic centimeters of urine. On the day following admission, complete anuria developed. On the third day after admission the creatinine had risen to 12.2 milligrams per cent and the N.P.N. was at 228 milligrams per cent. The potassium remained at 5.3 milligrams per cent. The patient was placed on a regimen of limited fluids with high fat and high carbohydrate intake. Ion exchange resins were employed.

Anuria persisted. On the fifth day after admission, renal dialysis was carried out. At this time the potassim was 6.6 millequivalents. Directly after the application of the mechanical kidney the creatinine had fallen to 7.2 milligrams per cent and the N.P.N. dropped from 232 to 106 milligrams per cent.

Twenty-four hours after dialysis, diuresis developed and the patient was followed with adequate restoration of potassium, sodium and chlorides. Her physical condition improved rapidly, her appetite increased, and her sense of well being improved proportionately.

Four days after the onset of diuresis, the N.P.N. had descended to 48 milligrams per cent and the creatinine had dropped to 2 milligrams per cent. At the time of discharge, 12 days after admission, the patient's potassium was 5.3 milligrams per cent, the creatinine was 2 milligrams per cent and the N.P.N. was 33 milligrams per cent. Her general status was eminently satisfactory.

Case Four

A 49 year old woman was admitted in April of 1961 to the Passaic General Hospital where aortic and mitral commissurotomy was performed by the open heart technic. For the first 24 hours after surgery the patient passed only 30 cubic centimeters of a dark brown urine. On the second post-operative day, she developed marked dyspnea and convulsive movements of the extremities. On the third post-operative day, clinical symptoms were progressively worse and the patient became stuporous and unresponsive. In view of her marked and rapid clinical deterioration, it was determined that dialysis should be attempted at this early stage because of the existing anuria and the rising potassium, creatinine and BUN. Accordingly, this procedure was done.

With the reduction in BUN and potassium the patient's convulsive symptoms ceased. She became more responsive and the stupor gradually diminished. Two days later in the presence of persistent anuria, uremic symptoms again developed with a concurrent rise in nitrogenous products. Four days after the first dialysis a second run on the artificial kidney was performed. Potassium which previously had been at 7.2 declined to a 3.8 milligrams per cent and the BUN fell from 96 to 61 milligrams per cent during the procedure. For several days thereafter, the patient's status seemed markedly improved. A small urinary output varying between 100 to 250 cubic centimeters per day occurred.

The improvement, however, was transitory and three days later deterioration again became apparent. The third dialysis was done eight days after the second episode. After this the patient made good improvement and continued progress then developed. Diuresis was established within 24 hours after the dialysis had ceased, then the patient rapidly recovered.

Summary

Mechanical dialysis is used in the treatment of acute renal insufficiency, intoxication with dialyzable non-nephrotoxic agents, selected forms of chronic renal disease, and intractable uremia, overhydration, or metabolic coma in patients with either surgically or medically reversible disease. In a period of five years, 36 patients have been dialyzed, using a disposable twin coil unit. The indications for dialysis must be determined in conjunction with medical measures to regulate acid-base and fluid balance, to supply calories, and to sustain the cardiovascular and respiratory function. Illustrative cases are presented to dramatize the need for proper diagnoses of the cause of anuria and uremia when they are present, for the proper medical management of such cases and for the avoidance of fatal delays in recognizing the necessity for dialysis when it is indicated.

Bibliography

1. Abel, J., Rowntree, L. G., and Turner, B. B.: *Journal of Pharmacology and Experimental Therapeutics,* 5:275 (January 1914)

2. Keleman, W. and Kolff, W.: *Archives of Internal Medicine,* 106:608 (November 1960)

3. Scribner, B. H., Buri, E., Raner, J. E., Hegstrom, R., and Bunnell, J. M.: *Transactions, American Society Artificial Internal Organs,* 6:114 (April 1960)

124 Gregory Avenue

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the course of the 1968 Annual Meeting in Atlantic City. Detailed minutes of these meetings are on file with the secretary of your component society. Below is a compilation of significant actions by meeting.

May 17, 1968

The final Board of Trustees' meeting for the administrative year was held in Atlantic City on May 17, 1968.

Legislation . . . Approved the report of the Council, including the following recommendations:

(1) That the proposed amendments to S-589 be approved. (See page 339, July 1968 JOURNAL — Supplemental Report #2, Council on Legislation — Amendments would improve wording of statement of S-589 and also delete reference to taking x-rays.)

(2) That the proposed amendments to S-526 be approved. (See page 339, July 1968 JOURNAL — Supplemental Report #2, Council on Legislation—Amendments would permit proper unit of hospital or medical service corporation, or insurance company access to data of utilization review committees.)

(3) That the recommended positions on additional bills currently in the Legislature be approved. (See page 338, July 1968 JOURNAL — Supplemental Report #2, Council on Legislation.)

MSNJ Abortion Survey . . . Reported that the Special Committee on Maternal and Infant Welfare concurred in the proposed following recommendation to the 1968 House of Delegates:

That the House of Delegates of The Medical Society of New Jersey affirm as its own the policy statement adopted by the AMA House of Delegates in June 1967. (See pages 301 and 302, July 1968 JOURNAL — Supplemental Report #2, Board of Trustees)

Cardiopulmonary Resuscitation Programs . . . Approved in principle the protocol prepared by the New Jersey Heart Association on cardiopulmonary resuscitation and requested that a final version be submitted for referral to MSNJ's Council on Medical Services.

AID Program . . . Approved the following recommendation of the Committee on Blue Cross-Blue Shield for referral to the 1968 House of Delegates: (See page 301, July 1968 JOURNAL—Supplemental Report #2, Board of Trustees.)

That it be recommended to the hospital administrators and medical staffs that a flag notice be put on the chart no less than 48 hours in advance of the estimated AID time for a given patient's discharge. If physicians thus alerted certify when certification is indicated, there will be no problem centering about delinquent certifications.

Resolutions of Appreciation . . . Approved two resolutions of appreciation for referral to the opening session of the 1968 House of Delegates: Robert Maddock Backes; Theresa Elizabeth Goeke (See page 370, July 1968 JOURNAL)

May 22, 1968

The reorganization meeting of the Board of Trustees, for the administrative year 1968-1969, was held in Atlantic City on May 22, 1968.

New Member . . . Welcomed Dr. E. Vernon Davis of Burlington County to the Board. (Dr. Davis was elected by the 1968 House of Delegates to the office of 2nd Vice-President.)

Chairman — 1968-1969 . . . Re-elected Dr. Frank J. Hughes of Gloucester as Chairman of the Board of Trustees for 1968-1969.

Secretary—1968-1969 . . . Re-elected Dr. Louis F. Albright of Spring Lake as Secretary of the Board of Trustees for 1968-1969.

Finance and Budget . . . Re-elected Dr. Nicholas E. Marchione of Vineland as a trustee-member of the Committee on Finance and Budget for a three year term.

MSNJ Acting Secretary . . . Designated Dr. Jerome G. Kaufman of Maplewood as Acting MSNJ Secretary, to serve during Dr. Greifinger's illness.

AMA Annual Meeting . . .Confirmed authorization of the following to attend the 1968 Annual Meeting of the American Medical Association to be held in San Francisco in June (with expenses paid): President, President-Elect, Executive Director, seven regular delegates, two alternate delegates (Dr. John J. Bedrick and Dr. Joseph R. Jehl).

. . . Authorized a telephone credit card for Dr. David B. Allman to assist him in his activities in behalf of the nomination of Dr. Joseph P. Donnelly to the AMA Board of Trustees.

Congress on Alcoholism . . . Confirmed authorization for Chairman of MSNJ's Committee on Alcoholism to attend the 28th International Congress on Alcohol and Alcoholism to be held in Washington, D.C. in September (with expenses paid).

Acting Legal Counsel . . . Appointed Mr. E. Powers Mincher as Acting Legal Counsel to the Society.

Legislative Analyst . . . Appointed Mr. E. Powers Mincher as Legislative Analyst to the Council on Legislation.

Referrals From 1968 House of Delegates . . .

(1) *Appointment of County Legislative Keymen* . . . Referred Resolution #20 (Delegates from Bergen County) to the Council on Legislation for implementation. (See Page 382, July 1968 JOURNAL)

(2) *Engagement of Legislative Personnel* . . . Referred the substitute resolution for Resolutions #2 (Essex County), Resolution #22 (Mercer County), Resolution #24 (Atlantic County), and Resolution #34 (Middlesex County) to the Council on Legislation (and authorized the Executive Director to meet with the Chairman and Vice-Chairman of the Council) to make appropriate recommendations to the Board for implementation. (See Pages 371, 384, 385, 392, 395, July 1968 JOURNAL)

(3) *Project Hope and Vietnam* . . . Empowered the President to set up a special committee of the Society to implement the recommendation from the Board (page 297, July 1968 JOURNAL) that Project Hope and Vietnam be established as a joint continuing program of MSNJ.

(4) *Homemaker-Home Health Aide* . . . Directed that Hospital Service Plan of New Jersey be informed of the action of the 1968 House of Delegates, upon recommendation of Reference Committee "C," concerning the Homemaker-Home Health Aide Project (to approve a pilot program). (See pages 294 and 397, July 1968 JOURNAL)

(5) *Assignment of Payment for Medical/Surgical Care* . . . Referred the information contained in Resolution #18 (Delegate from Essex County), as amended, to the Health Insurance Council (See Page 381, July 1968 JOURNAL)

(6) *Community Health Week* . . . Directed that Resolution #5 (Essex County) be referred to the AMA Board of Trustees (See Page 374, July 1968 JOURNAL)

(7) *Utilization Committees* . . . Directed that the information contained in the recommendation from the House of Delegates that utilization committees be established in each county and that complaints of the fiscal intermediary be referred to either the utilization or judicial committee of a county society, when indicated, be transmitted to all component societies and the fiscal intermediary for Medicare, Part B. (See page 341, July 1968 JOURNAL)

(8) *Title XIX* . . . Directed that the information contained in a recommendation from the House of Delegates that a joint committee of MSNJ and the Department of Institutions and Agencies discuss all aspects of Title XIX

legislation in New Jersey, conferring with legislators as often as requisite, and that if necessary a special session of the House of Delegates be called to consider such legislation, be referred to the Council on Medical Services. (See page 341, July 1968 JOURNAL)

. . . Directed that the Chairman of the Council on Medical Services be authorized to act with our present liaison representatives, Dr. Francis Benz and Mr. Maressa.

(9) *Physicians on Hospital Governing Bodies* . . . Directed that the substitute resolution for Resolutions #1 (Bergen County), #13 (Morris County), and #16 (Union County) be referred to the AMA Delegates. (See pages 371, 378, 380, 404, July 1968 JOURNAL)

(10) *Standardized Insurance Forms* . . . Directed that Resolution #31 (Camden County) be referred to the AMA Delegates. (See page 390, July 1968 JOURNAL)

Convention Manager . . .Commended the staff of MSNJ for the success of the Annual Meeting and extended to the Convention Manager, who is recuperating at home, congratulations and best wishes.

Scientific Exhibit Awards

At the 202nd Annual Meeting of The Medical Society of New Jersey, three award plaques and five honorable mention certificates were designated for outstanding scientific exhibits.

The first award plaque, presented by MSNJ for a scientific exhibit of individual investigation, judged on the basis of originality and excellence of presentation, went to the authors of "Routine Immunohistology as an Aid in Diagnosis and Therapy of Renal Diseases," Kurt Lange, M.D., Gerhard Treser, M.D., Edward Wasserman, M.D., Theodore Ehrenreich, M.D., Richard Ores, M.D., and Antonia Ty, M.D. of the New York Medical College, Flower and Fifth Avenue Hospitals, New York City.

Second place was awarded for "Neuroradiology in the Community Hospital," by David L. Bloom, M.D., Richard J. Byrne, M.D., M. D. Ozonoff, M.D., Allan W. Newcomb, M.D., and Fred M. Palace, M.D. of the Morristown Memorial Hospital in Morristown.

The "Aesculapius Award," provided by Mead Johnson and Company to a scientific exhibit authored by a member of The Medical Society of New Jersey, which includes a plaque and check in the amount of $200, went to Russell W. Brancato, M.D. and Nicholas A. Antonius, M.D. of the St. Michael Hospital in Newark for "Coronary Cineangiography."

The Honorable Mention Certificates were awarded as follows:

"Management of the Multiple Sclerosis Patient" by George J. Boines, M.D. of Wilmington, Delaware.

"Leprosy Alert" by Albert L. Rosenthal, M.D. and Thomas K. Rathmell, M.D. of The Mercer Hospital in Trenton.

"Community Hospital Hemodialysis" by Seymour Ribot, M.D., Martin Jacobs, M.D., and I. Richard Zucker, M.D., Newark Beth Israel Hospital, Newark.

"Stereotaxic Surgery — Treatment of Parkinsons' Disease, Pain, Movement Disorders, Intractable Psychoses, and Convulsive States" by George A. Zazanis, M.D. and Henry R. Liss, M.D., Morristown Memorial Hospital in Morristown.

"Mesothelioma and Asbestos Exposure" by Maxwell Borow, M.D., Sylvan E. Moolten, M.D., Alfred S. Conston, M.D., Lawrence L. Livornese, M.D., and Norbert Schalet, M.D., Middlesex General Hospital, New Brunswick, and Somerset Hospital, Somerville.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the months of May and June:

	May 1968	*May 1967*
Aseptic Meningitis	6	9
Primary Encephalitis	4	5
Post-Infectious Encephalitis	1	1
Hepatitis, Total	164	104
Infectious	148	81
Serum	16	23
Malaria (Servicemen)	5	6
Meningococcal Meningitis	19	15
Mumps	460	*
German Measles	361	*
Measles	149	115
Salmonella	65	37

	June 1968	*June 1967*
Aseptic Meningitis	10	9
Primary Encephalitis	5	0
Post-Infectious Encephalitis	0	1
Hepatitis, Total	178	94
Infectious	161	74
Serum	17	20
Malaria (Servicemen)	9	17
Meningococcal Meningitis	12	6
Mumps	223	*
German Measles	215	*
Measles	108	44
Rocky Mt. Spotted Fever	1	2
Salmonella	39	69
Shigella	5	23

* Reporting only since October, 1967.

Poliomyelitis

New Jersey has not had a case of poliomyelitis for more than two years, yet only last summer there were two confirmed cases in Philadelphia.

Pockets of unimmunized pre-school children exist in many of our cities. Surveys last summer demonstrated this in Paterson, Atlantic City, and Jersey City. A low economic census tract in Paterson revealed that only 21 per cent of children (one to five years old) had a satisfactory immunization level. An immunization program was held there in December 1967. In selected areas of Jersey City and Atlantic City 24 and 17 per cent of the pre-school children were unimmunized. Trivalent poliomyelitis vaccine is provided for all New Jersey residents who need be spared the cost. This vaccine can be obtained at any of the 66 distributing stations throughout the state.

Fifth Disease

In May 1968, letters describing the clinical picture of *erythema infectiosum* were sent to physicians, health officers, and school superintendents. By the end of that month, 1463 cases of asymptomatic rash illness resembling this disease were reported to our State Department of Health. The geographical distribution is widespread, with all but two counties reporting cases. Most cases, however, are in the Metropolitan and Central Districts. Many calls have been received from school nurses about the advisability of exclusion from school. This decision has been left to the school physician. If he is certain that he is dealing with fifth disease (and not measles or rubella — and this can usually be determined by the second or third day of rash) then it seems reasonable that the child be allowed to remain in school.

Measles

In the first four months of 1968, there have been 307 cases of measles reported by the New Jersey State Department of Health. This represents an 11 per cent increase over the number of cases in the same time period in 1967. A surveillance system has been useful in eliminating misdiagnosed cases. Health departments have generally reacted to outbreaks of measles by organizing measles campaigns. An "active" program of immunization before outbreaks start is equally as important as the "reactive" policy of fire-fighting.

Reaction to Measles Vaccine

On June 5, 1968, 516 children were given Schwarz strain measles vaccine by jet injector gun in a measles immunization program held in parochial and public schools in Orange. On June 25, 1968, the parents of 256 children participating in the program were contacted by telephone regarding symptoms possibly associated with the measles immunization. The most frequent symptom, occurring in 12 per cent of the children, was mild local tenderness lasting less than a day at the vaccination site. Mild fever, rash, and upper respiratory symptoms were noted in less than 8 per cent of the

children. Only 1 per cent had symptoms of sufficient severity to warrant telephoning the private physician and only one of the children immunized (less than 0.5 per cent of the sample) was actually seen by a physician. That child had a slight fever and rash lasting less than 48 hours. It is noteworthy, that this study did not have a control group of unimmunized children who were contacted regarding symptoms during the same time period. It is possible that such a control group could have had as much morbidity. This experience is in agreement with reports in the medical literature as to the minimal reactions to be expected from immunization with the further attenuated measles vaccine.

Hospital "Outbreak" of Salmonellosis

In early June, this Division received a request from a large hospital for assistance in the investigation of a presumed intra-hospital outbreak of salmonellosis. Seven isolations of Salmonella *typhimurium* had been obtained from patients at the hospital over the preceding 10 day period. Review of the patients' charts showed that they resided in different municipalities, had an age range of 17 to 77 years, and were admitted to different hospital floors with different medical problems. The one common factor was that they were all admitted with fever and had blood cultures taken. These blood cultures were positive for salmonella. Only one patient had a stool culture positive for salmonella. Five out of the seven blood cultures contained more than one organism, such as herellea, streptococcus faecalis, or enterococci, in addition to the salmonella. None of the patients had a clinical course compatible with salmonellosis. Because of the multiple organisms in the blood cultures, and the lack of any epidemiologic association among the cases, contamination of the cultures was suspected as the cause of the "outbreak." Different members of the housestaff were involved in taking the cultures via disposable closed-system tubing and vacutainer bottles. Cultures of this equipment and the antiseptics used in preparation of the arm showed no bacterial growth. Review of the procedures in the bacteriology laboratory disclosed that the technics for blood cultures had been altered at about the same time that multiple organisms began to appear in the blood cultures. The change in technic involved entering the sterile blood culture vacutainer bottles after a 24 hour incubation period for subcultures and Gram stain smears. It is presumed that inadvertent contamination of the cultures had occurred with the new method. A subsequent revision in the culture technics ended the "outbreak." Multiple organisms in a blood culture should always suggest contamination, and indicate repeat blood cultures before initiation of therapy.

Typhoid Vaccination in Flooded Areas

Due to the recent flooding in New Jersey the use of tyhoid vaccine was raised. The State Health Department does not recommend its use in this situation. The risk of typhoid in New Jersey is small. Secondly, by the time immunity to typhoid is built up via vaccination, the risk of typhoid is over. A period of about one month is required for effective protection by the vaccine, whereas the usual incubation for typhoid is 10 to 17 days though it may be up to 30 days.

The effectiveness of Paratyphoid A and B vaccines has never been proved. Furthermore, they decrease the effectiveness of typhoid vaccination and when combined with typhoid vaccine they may increase the occurrence of vaccine reactions.

Non-Human Primate Associated Hepatitis

Recently the Communicable Disease Control Section investigated five cases of hepatitis in men who were in close association with monkeys. The chimpanzee has been implicated in several outbreaks of hepatitis. These are usually immature animals and recently imported into the United States. The human disease is indistinguishable from typical infectious hepatitis. Clinical illness in the animal is rare. Wooley monkeys and Celebes Apes have also been associated with human cases of hepatitis but the evidence is less convincing than for chimpanzees.

International Notes

We have been urged by the World Health Organization and the U.S. Public Health Service to call attention to the fact that confusion has arisen regarding the method of recording dates on the International Certificates of Vaccination. They request that all dates should be recorded in the following sequence:

	Day	*Month*	*Year*
e.g.	2	May	1968

Difficulties continue to arise because of the use of arabic figures for recording the month. In the United States (and some other countries) it is the custom to write the month (either in letters or arabic numerals) *before* the day. However, it is a common practice in many other countries to follow the format indicated above. Thus, an American physician who vaccinated one of his patients on November 2, 1965 may have written the date as "11/2/65." A European Quarantine Inspector would assume that a Certificate had been issued on February 11, 1965. He would, therefore, consider the Certificate invalid because of issuance more than three years prior to the present time. No misinterpretation is possible, however, if the date were indicated as prescribed by WHO, that is: "2 Nov. 65."

Improvement In Premium Rate For Disability And Dismemberment Policies For Younger Members

Nationwide Mutual Insurance Company

(Basic Policy)

Monthly Benefits	Accidental Dismemberment Benefits	Ages Under 40	Ages 40 through 49	Ages 50 through 59	Ages 60 and over
$100	$ 5,000	$ 25.40	$ 29.50	$ 34.00	$ 43.00
200	10,000	49.50	57.70	66.70	84.70
300	15,000	73.60	85.90	99.40	126.40
400	20,000	97.70	114.10	132.10	168.10
500	20,000	120.80	141 30	163.80	208.80
600	20,000	143.90	168.50	195.50	249.50

National Casualty Company

(Basic Policy)

Monthly Benefits	Accidental Dismemberment Benefits	Ages Under 40	Ages 40 through 49	Ages 50 through 59	Ages 60 and over
$100	$ 5,000	$ 25.60	$ 30.20	$ 34.70	$ 43.70
200	10,000	49.70	58.90	67.90	85.90
300	15,000	73.80	87.60	101.10	128.10
400	20,000	97.90	116.30	134.30	170.30
500	25,000	122.00	145.00	167.50	212.50
600	30,000	146.10	173.70	200.70	254.70

The above premiums for those under age 40 are lower by about 15 per cent. The rates for those age 40 through age 49 had previously applied to all under age 50; the premiums for those above age 50 remain unchanged.

In times of rising costs it is a pleasure to be able to announce a reduction in essential services to the membership.

Committee on Medical Defense and Insurance

The Arthur Brisbane Child Treatment Center

In New Jersey, the Arthur Brisbane Child Treatment Center is the only state-operated psychiatric residential treatment facility for mentally ill children which is separate from a state mental hospital. With a maximum bed and treatment capacity of 92, the present program provides for 9 girls and 83 boys between the ages of 5 and 12 from any of the 21 counties.

Children with a variety of diagnoses including schizophrenia and brain damage may be eligible for admission. The children at Brisbane live in an "open" setting and participate in an educational program and in a variety of outdoor activities. Determination of acceptability is made by the staff at Brisbane on the basis of the suitability of our program for the child and on the availability of space.

Referrals may be made by physicians or agencies in a letter to the Medical Director. The letter should state the child's problem, the gains expected from residential treatment, and should indicate what professional personnel or agencies in the community will be able to continue to assist in the long-range treatment plan. Included with the letter of referral should be:

(1) A report of a psychiatric examination and an evaluation which has incorporated the pertinent findings of the medical, psychologic, social service, and school histories.

(2) Detailed reports and recommendations of the individual services mentioned above and the reports of any treatment or counseling sessions.

If this material suggests that the child could not benefit from Brisbane's program, the referring physician or agency is notified and is given suggestions for alternate plans which may include combining a number of different services. If, on the other hand, it seems that Brisbane's program might meet the child's needs and a vacancy is expected within 3 months an appointment will be made for the child and his parents or guardian at Brisbane. Such an appointment provides the Brisbane staff with the opportunity of evaluating the child in the setting and of discussing the Brisbane program and procedures with the child and his parents or guardian. This personal contact enables Brisbane's staff to make a final determination of acceptability of the child for admission. A treatment plan which spells out the goals for the child and proposals of helping him achieve them during his residence at Brisbane is formulated. The referring physician or agency is then notified of the decision and of the approximate date of admission. A child may have to wait from one week to several months for admission, since it is difficult to anticipate the specific date of a vacancy.

In the event that the referral material on a child suggests that the child would benefit from Brisbane's program but no vacancy within 3 months is anticipated, the physician or referring agency will be notified and will be sent recommendations for alternatives.

It is not our practice to develop a waiting list. The conditions which prompt referral of a child for residential treatment usually necessitate his receiving the required treatment promptly. If this cannot be obtained at Brisbane, the second best alternative should be implemented.

Average length of stay for the children discharged in 1967 was 2 years. This is expected to shorten as we intensify our therapeutic residential program and increase our coordination with the community to smooth the transition to other phases of the treatment plan.

Private and other referrals are accepted. The County Adjuster of the County of residence of the child determines the amount to be paid by the parents. The maximum weekly rate is determined by the State House Commission. The private rate at Brisbane for 1968 is established at $73.78 a week or $10.54 a day. The address is Arthur Brisbane Child Treatment Center, Allaire (Farmingdale Post Office), New Jersey. Phone 201-938-2341.

Evelyn Parker Ivey, M.D.
Medical Director

Accolade To Dr. William F. Costello

Each year, the eagerly sought after and highly prized "Community Service Award" of the Greater Dover-West Morris Chamber of Commerce is presented to a citizen who has contributed above and beyond the norm to the benefit of the area and its residents.

Dr. William F. Costello was the recipient of this award for the year 1968. The Dover *Daily Advance* put it this way: "The recipient of this Award is one of the most respected, best known and best liked individuals in the Dover area.

"We can think of no one more deserving of the tribute and we are sure that many of our readers feel the same way.

"Dr. Costello delivered more babies in his 55 years of service here than any other physician in the area.

"He is a past president of the Morris County Medical Society, and a former vice-president of the American Medical Association. For 39 years, he served on the Dover Board of Health—35 of them as president.

"He has been a member of the Board of Directors of the Dover Trust Company for the past 30 years and served as Morris County physician for more than 13 years.

"His ready wit and his love and knowledge of sports have endeared him to many people.

"Along with the Chamber of Commerce, we join in saluting Dr. Costello.

"He was a personal friend of the late great John McGraw and brought Babe Ruth to Dover for an exhibition game at Hamilton Field in 1920.

"His accomplishments would fill a book. The fact that he has many friends in the Dover area was easily recognizable Saturday night."

What You Can Do About Air Pollution*

The Department of Environmental Sciences at Rutgers University suggests the following list of things that the private citizen can do about air pollution. These suggestions can be obtained from Rutgers in the form of small flyers for your waiting room table.

DIRECT ACTION

1. Keep your home furnace clean, adjusted properly and operating efficiently.
2. Your automobile should be kept tuned for efficient combustion. Have the following checked periodically and adjusted or replaced: carburetor, fuel pump gaskets, timing, blow-by valves, fuel tank, filler tank cap gasket, oil filter cartridge, spark plugs, cooling system, and thermostat.
3. Operate your automobile properly. Avoid quick stops and starts; avoid racing the motor. Jamming on the brakes will cause particles of brake linings and rubber particles from tires to be thrown into the atmosphere.
4. Use public transportation or walk whenever possible.
5. Gasline-powered tools such as lawn mowers and snow blowers should be kept adjusted and in top condition.
6. Do not burn paper, trash or garbage.
7. Store garbage and rubbish in a covered, watertight receptacle. Keep covered at all times.
8. Make sure that you have garbage ready for regularly scheduled pick up. Do not allow accumulation by forgetting to put the containers at the curb.
9. Do not burn leaves or garden cuttings. Put in containers for pick up by disposal service. If you wish to compost the organic matter, avoid conditions for growth of fungi.
10. Household dust collected by mops or vacuum bags should be disposed into a receptacle to avoid dispersion into the air.
11. Open areas in your yard should be put into lawn or artificial cover to minimize dust blowing.
12. Apartment dwellers should carefully obey incinerator regulations concerning type of refuse and operating procedure.
13. Constantly check for ragweed growths and eradicate them. Cut all weeds before ragweed season.
14. Keep your property clean including sidewalks and curb areas if necessary.

* Prepared by Raymond M. Manganelli, Ph.D., Department of Environmental Sciences, Rutgers University, New Brunswick, New Jersey.

15. Avoid outdoor spraying or spreading of chemicals as insecticides, weedicides, lime, paint on windy days.

16. When you are having an outdoor barbecue, properly prepare fire to avoid excessive smoking. Do not burn paper dishes, cups and refuse in the charcoal burner.

17. Proper care of pets should be exercised to keep animals healthy and to prevent spread of waste, hairs etc.

18. Water and waste water should not be allowed to accumulate and become stagnant.

19. Make a poll of air pollution sources. How many different types of sources can you observe and list?

20. If you would like to estimate the approximate amounts of a *few* of the *pollutants* emitted to the atmosphere by your home furnace and your automobile, carry out the following calculations:

    a) Compute the quantity of fuel you burn in your furnace a year. Record your figure in following terms: for coal use *tons;* for fuel oil use *units* of *1000 gallons;* for natural gas use units of *million cubic feet.*

    b) Compute the quantity of gasoline (in units of 1000 gallons) consumed by your automobile in a year.

    c) Multiply the above units by pollutants. (Compilation available from Rutgers.) This will give you the total pounds of a certain pollutant emitted in a year.

    d) The Table was derived from a compilation prepared by Martin Mayer, Public Health Service, Cincinnati, Ohio (May, 1965).

    e) Quantities of pollutants emitted by incinerators can be calculated using a compilation which will be furnished by the University.

ACTION THROUGH MUNICIPALITY

1. Take an interest in zoning and planning actions of your municipality. Serious problems have been created by improper zoning or granting of unjustified variances. Good planning is an integral part of effective air pollution control.

2. Support development of green belts in your community.

3. Obtain copies of your local ordinances to learn what is being controlled and what the gaps are. Obey the codes.

4. Find out what agency and what official of your community (region or state is responsible for air pollution control actions.

5. Give support to your local control agency so that sufficient budget will be provided for effective action.

6. If you observe an air pollution problem or an effect report it to the duly authorized control official.

7. Your county agricultural agent will help you in identifying air pollution damage to vegetation as well as in the recognition of allergenic weeds.

AWARENESS

1. Keep informed about the problem of air pollution and its solution. The best way to obtain information and to learn about other sources of authoritative information is to communicate with your State University. In New Jersey you should write to Agriculture and Environmental Science, Rutgers University, New Brunswick.

2. Share your information with your family, friends, and co-workers.

3. If you are a member of an *organization* that is interested in learning about air pollution control, communicate with College of Agriculture and Environmental Science, Rutgers University, New Brunswick, for suggestions on group activities as well as seminars and speakers.

4. It is important that we keep air pollution in proper perspective. We are all contributors and we are all receptors. Wherever we go, and whatever we do for the 24 hours of each day, we breathe and we are intimately exposed to our atmosphere. We all have a responsibility to clean it. The effort and cost are a necessity.

AMPAC Creed

I am a free citizen in a free nation.

Whoever diminishes my freedom as an individual diminishes the sum total of freedom in my country.

I am also a physician, free thus far to treat my patients to the best of my ability.

Abridge that freedom and the health of my patients is adversely affected.

These things being true, I cannot—I will not—stand idly by when these hard-won freedoms are under attack.

For I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

I believe that I, as a free citizen in a free land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

Therefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government.

Dr. Edward W. Sprague Honored By National Blue Cross Association

Dr. Edward W. Sprague, a prominent figure in New Jersey medical circles, was honored on April 25 by the Board of Governors of the National Blue Cross Association for 30 years of service as a trustee of Hospital Service Plan of New Jersey (New Jersey Blue Cross Plan). Dr. Sprague, who has received numerous accolades during his career, was awarded a plaque by Earl R. Mellen, chairman of the Blue Cross Board of Trustees, and Duane E. Minard, Jr., Blue Cross president.

The plaque cites Dr. Sprague as a man "whose individual and steadfast faithfulness to its ideals and objectives have helped make Blue Cross one of the major socio-economic developments of the Twentieth Century."

Dr. Sprague's career has been studded with noteworthy achievements. In addition to his lengthy service as a Blue Cross trustee he played a prominent role in the creation of the Medical – Surgical Plan of New Jersey (New Jersey Blue Shield Plan). A founder and former member of the Blue Shield Board, he was honored by the special title "Trustee Emeritus" in 1966 when he retired from the Board after 24 years of service.

Dr. Sprague has received the Edward J. Ill Award of the Academy of Medicine of New Jersey, the National Award of the American College of Surgeons, of which he is a Fellow, and the Society of Surgeons of New Jersey Award.

A senior surgeon at St. James Hospital, Dr. Sprague, a Protestant, was made a knight of St. Sylvester of the Roman Catholic Church in 1965 in honor of his long service at that hospital.

In addition to his post at St. James, Dr. Sprague is a senior surgeon at Presbyterian and Newark City Hospitals, and a consulting surgeon at Mountainside, Clara Maass, and Irvington General Hospitals. He is a trustee of United Hospitals of Newark and a past director of the Prudential Insurance Company of America.

America's Largest M.D. Award

The first receipient of the Sheen Award was Dr. Irvine H. Page of Indianapolis. Dr. Page is known to all of us as a pioneer in hypertension, cardiac and renal disease, and human biochemistry, generally. To New Jersey physicians this Award is of special significance since it was established by an Atlantic City businessman, the late Thomas G. Sheen. The Award includes a cash prize of $10,000 which makes it, it is believed, the largest American award ever available to a physician. A three-man committee will each year select the winner, and Dr. David B. Allman is one of the three. The other M.D.-member of the Award Committee is Dr. G. D. Dorman, an AMA Trustee. Speaking for the AMA, Dr. Dorman, said that:

"The American Medical Association considers it an honor to participate in the nomination and presentation to Dr. Page of the first Dr. Rodman E. Sheen and Thomas G. Sheen Award. This Award honors the memories of two Atlantic City men who were truly concerned about the health and welfare of their fellow Americans.

"One of them, Dr. Rodman E. Sheen, was a pioneer in the medical use of roentgen rays. This work led to a tragic accident which cut short his career as a physician. His brother, Thomas G. Sheen, was a successful businessman whose great affection and solicitude for his physician-brother impelled him to make possible this award.

"Over the years, this prestigious award will recognize many physicians whose dedication and contributions to medical science have added materially to the well-being of all mankind."

Thomas Sheen, a tailor, clothier, and real estate man before he died in 1938, directed the estate executor to establish a trust fund with the income annually to go for the award "to the outstanding Doctor of Medical Science in the United States for each year. My Trustee is to award the prize to such doctor as

he may select. My purpose in creating this award is to further the study of medicine and medical science and to compensate the doctors who have each year done something outstanding in the medical profession."

The fund was set up, as the will stipulated, after the death of Thomas Sheen's sister, brother, and nephew. Alvord, the last survivor, died earlier this year.

Dr. Allman recalled that Dr. Sheen was badly disfigured when an x-ray tube exploded in his face. This seriously impared Dr. Sheen's eyesight, and drove his devoted brother to stimulate further research in all aspects of medicine. Thomas Sheen felt a deep gratitude for physicians who were doers, who accomplished things, whose work included landmarks of medical progress — hence this unique Award.

The Ethics Of A "Weight Control" Specialty In Medicine

It is the policy of the AMA House of Delegates that there is no ethical or legal bar to any physician limiting his practice to the treatment of obesity. "However," said the AMA spokesman (in testimony before Congress) "this is *not* a recognized specialty. Since obesity may be only a sign of some underlying medical disorder, many disciplines and specialties of medicine may be involved in the proper care of the obese patient."

While the practice of weight-control is ethical and proper, the misuse of medical procedures or the failure to render acceptable medical care to individual patients was condemned. Medical societies have an obligation to protect the people in their community from physicians who are not practicing high-standard medicine.

The AMA's Law Division agrees that medical societies might properly review the practices of some physicians who deal exclusively in the area of weight-control. If physicians engaged in that type of practice are not taking adequate histories, not conducting adequate physical examinations, are over-prescribing, or are prescribing medications not established as safe and efficacious, then they are guilty of unethical conduct and under some conditions, may even be liable for malpractice.

However, a disapproving medical society would have to prepare its case thoroughly, and clearly state before the Ethics Committee the objectional practices the doctor was following. And medical society officials would have to justify before the Ethics Committee that the accepted practice in the community was of a different nature. They would also be asked to give their opinion on *why* the practice described was contrary to sound medical judgment. Medical expert witnesses would have to establish the standard of care in the community and show that the type of care under consideration was, in the opinion of the medical community, harmful or impossible of accomplishing good from the medical point of view.

The Law Division suggests that, in all probability, a charge could be brought under, Section 3 of the *Principles of Medical Ethics.* This reads as follows:

3. A physician should practice a method of healing founded on a scientific basis; and should not voluntarily associate professionally with any one who violates this principle.

Correction

May we please call to our readers' attention an omission in the article, "The New Jersey Regional Medical Program Progress And Plans," by Alvin A. Florin, M.D. and James P. Harkness, Ph.D. (page 257, June 1968 JOURNAL). The list of founding health organizations of the New Jersey Regional Medical Program should have included the *American Cancer Society, New Jersey Division* (paragraph 2 of the article).

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

DERMATOLOGY—Robert J. Carnathan, M.D., 1043 Fernwood Avenue, Maple Shade, New Jersey 08052. Georgetown 1962. Association with dermatologist, or multispecialty group. Available.

William Lefing, M.D., Skin and Cancer Hospital, 3322 North Broad Street, Philadelphia, Pennsylvania 19140. Seton Hall, 1962. Solo or multispecialty group. September 1, 1968.

GENERAL—Loren T. Burns, M.D., 7 West 14th Street, New York 10011. University of Illinois, 1967. Available.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connectciut 06516. Boston University, 1962. Group. Available.

Harry M. Friedland, M.D., 2329 South Cedarbrook Road, Springfield, Missouri 65804. Downstate Medical Center (NYU), 1961. Subspecialty, Gastroenterology. Available.

Richard Kroner, M.D., 3750 Hudson Manor Terrace, Riverdale, New York 10463. New York Medical, 1964. Group. Available.

Edgar Lichstein, M.D., 1777-F Arlin Village Place, Fairborn, Ohio 45324. Downstate Medical Center (NYU), 1961. Board eligible Subspecialty, cardiology. Available.

Allan M. Sulzer, M.D., APO New York 09254, Tuslog Det. 37. University of Pittsburgh, 1964. Locum Tenen — November 1968-June 1969.

Irving Schiffman, M.D., 2025 A Werner Park, Fort Campbell, Kentucky 42223. Downstate Medical Center 1959. Board Certified. Subspecialty, Cardiology. Group or partnership. Available August 1968.

Raymond L. Hargrove, M.D., 44 Norman Place, Box 113, Tenafly, New Jersey. University of Pennsylvania, 1961. Board eligible. Subspecialty, gastroenterology. Group. Available July 1969.

Stanley Feld, M.D., 24 Heather Road, Watertown, Massachusetts 02172. Downstate Medical Center, 1963. Board eligible. Sub-specialty, Endocrinology. Group. Available.

OBSTETRICS AND GYNECOLOGY—Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo, 1961. Board certified. Available.

Arnold J. Halpern, M.D., 516 Almond Court, Hampton, Virginia 23369. Jefferson, 1959. Board certified. Available.

Nicholas J. Criares, M.D., 8121-D Colorado Street, Wurtsmith A.F.B., Michigan 48753. St. Louis University, 1960. Board eligible. Group or associate. Available.

Lawrence N. Margolies, M.D., 12510A Turner Circle, Omaha, Nebraska 68123. Columbia 1962. Board eligible. Available.

PEDIATRICS — James Sorger, M.D., 27 Warner Arms, Warner Robins, Georgia 31093, NYU Medical, 1963. Board eligible. Solo, group, partnership, or association. Available.

SURGERY—Dennis M. Wadler, M.D., 245 East 25th Street, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available.

Morton H. Goldstein, M.D., 3411 Wayne Avenue, Bronx, New York 10467. University of Chicago, 1959. Board certified. Plastic. Available summer 1968.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York, Downstate Medical Center (NYU), 1960. Board certified. Pediatric. Available.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part 1. Group or solo. Available.

Robert Wegryn, M.D. St. Mary's Hospital, 89 Genesee Street, Rochester, New York 14611. Cornell, 1963. Board qualified. Group or partnership. Available August 1968.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riverside, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available.

Stanley W. Gensler, M.D., 3rd Surgical Hospital, Dangtam, Vietnam, APO 96372. Albert Einstein, 1961. Board certified. Partnership or group. Available.

Physicians For Viet Nam

As indicated in previous items in this space, New Jersey has sent fewer physicians, *pro rata*, than most other states to the AMA "Volunteer Physicians for Viet Nam" program. The summer 1968 roster, for example, includes only three from our State: Dr. William Hall of Princeton, Dr. Z. C. Taintor of Cape May, and Dr. Joan Burgess of Flemington. See pages 591 and 624, November 1967 (Vol. 64, #11) of *The Journal* for details of the program.

ANNOUNCEMENTS

Symposium on Coronary Care

The New Jersey Heart Association and the State Department of Health will sponsor a two-day seminar for administrative health personnel at Atlantic City's Holiday Inn on September 20 and 21, 1968. The meeting, which will be the first of its kind to be held in New Jersey, will be entitled "The Coronary Care Unit - The Heart of the Community" and will be aimed at filling a current gap in planning, design, equipment, financing, and staffing of hospital coronary care units.

These units (fitted with the latest electronic heart monitoring equipment) have proved effective in curtailing patient failure following cardiac surgery or heart attack episodes. The CCU is usually designed to house 6 to 10 patient stations, each equipped with monitoring devices, and a centrally located, viewing area from which skilled personnel can continuously observe and instantly respond to fluctuations in heart performance.

The primary goal of this meeting will be to bring complete information on the status and theory of the coronary care unit to the decision making people in New Jersey.

The program will give consideration to the expanding role of the nurse and the physician-nurse relationship in the CCU, as well as other aspects of heart patient care. Highlighting the weekend session will be Dr. Thomas Killip, Assistant Professor of Medicine at Cornell University, who will review the changing theories of care and treatment in coronary care units, and Dr. Ernest McMahon, Dean of the University Extension at Rutgers, who will discuss the need for continued training of CCU personnel. David C. Juiliano, a prominent CCU architect from Chicago will outline the blue-print and cost aspects of coronary care unit planning. There will also be a panel discussion headed by Mary Bielski, R.N., of Cornell University Medical College; Rose Pinneo, R.N., of the University of Rochester; Dr. Lawrence Meltzer, of the Pennsylvania Medical Center; and Dr. John Helwig, Director of CCU at the Germantown Hospital.

Guests at the Friday evening dinner will be entertained with a half-hour play, *Arrival of a Stranger*, which will be staged by the Little Theatre Group of New York City. This play will deal with the story of a heart patient and problems encountered on his return home, emphasizing the need for treatment of heart patients in planned stages prior to and following release from the hospital.

Course In Medical Hypnosis

September 26, 1968 will be the first of 20 Thursday afternoon sessions devoted to medical hypnosis. Each session runs from 1 to 5 p.m. and includes supervised practical work. The course will be given at 111 North 49th Street in Philadelphia under the sponsorship of the University of Pennsylvania. For more information, write to Division of Graduate Studies, 237 Medical Laboratories, University of Pennsylvania, Philadelphia 19104.

Psychiatry For Medical Practitioners

Starting on September 26, and for 12 Thursday afternoons thereafter, you can participate in a course on practical psychiatry for non-psychiatric physicians. This will include material on psychosomatics, marital problems, depression, adolescent problems, addiction, anxiety, and the use of modern medications in psychiatry. Included is observation through a one-way mirror of live psychiatric interviews with analysis of the dialogue. Sponsored by the University of Pennsylvania, this course will be given in Philadelphia. For more information, write to Dr. Sydney Pulver at 111 North 49th Street, Philadelphia, 19139.

Congress On Occupational Health

September 30 is the date and New York's Waldorf-Astoria is the place for the AMA Congress on Occupational Health. The program includes seminars, papers, and discussions on emotional factors in the environment of health, on the accident process, on alcoholism, on low back injury, on cardiopulmonary resuscitation, and on the confidentiality of industrial medical records. There will also be material on tuberculosis and employment, on women workers, on automation of laboratory procedures, on airline medical management, and on rehabilitation in Viet Nam. The conference is acceptable for 11 hours by the AAGP. There is no registration fee. For full program and registration details, write to Occupational Health Council, AMA, 535 North Dearborn Street, Chicago 60610.

Courses In Hypnosis

Columbia University College of Physicians and Surgeons announces its annual graduate course in *Medical Hypnosis,* under the direction of Herbert Spiegel, M.D., to be held Saturdays 10 a.m. to 5 p.m. October 5 to November 16, 1968. Lectures, case demonstrations, practice sessions, movies, and seminars are designed to present technics and theories of hypnosis and to demonstrate the adjunctive uses of hypnosis in clinical medicine. It is open to general practitioners and specialists.

This is followed by *Hypnosis and Psychiatry* and is open only to psychiatrists who have taken the basic hypnosis course or the equivalent. Lectures, seminars, and case material are presented to show hypnosis can facilitate the psychotherapeutic process — four Saturdays 10 a.m. to 5 p.m. January 4 to 29 in 1969.

For information write to: Melvin D. Yahr, M.D., Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York, New York 10032.

Course In Legal Medicine

Starting on October 9, 1968, and for the nine following Wednesdays, you can take a course in medical jurisprudence and forensic medicine sponsored by the Pennsylvania Hospital. Meetings are in Philadelphia from 1 to 3 p.m. and the tuition fee is $50. For further details, write to Dr. Sydney Pulver, 111 North 49th Street, Philadelphia 19139.

Course In Gastroenterology

The American College of Gastroenterology announces that its annual course in Gastroenterology will be given at the Statler Hilton in Boston, on October 31, and November 1 and 2, 1968. A star-studded faculty has been lined up from the medical schools in the Boston area. The matter to be covered in the course, will include advances in diagnosis and treatment of gastrointestinal diseases plus a comprehensive discussion of diseases of the esophagus, stomach, pancreas, liver and gallbladder, and colon and rectum. In addition there will be individual papers and films of interest.

For further information, write to the American College of Gastroenterology, 33 West 60th Street, New York, New York 10023

Chest Disease Seminar

The New Jersey Tuberculosis and Health Association announces its annual meeting November 13, 1968, at the Nassau Inn, Princeton. Theme of the program is "Where the Action Is in TB-RD Control?"

Dr. Abram Kaplan of the Albert Einstein Medical Center at Temple University will speak on "Resources for Care and Treatment for Emphysema." Dr. Charles R. Ream, physician-in-chief at St. Elizabeth's Hospital, Elizabeth, will discuss "Tuberculosis in the General Hospital," Miss Frances P. Koonz, director of Nursing Advisory Service of the National Tuberculosis and Respiratory Disease Association, and Robert Boyd, administrator of the Morristown Memorial Hospital, will join in a panel discussion on the convention theme. K. W. Grimley, executive secretary of the Alabama TB Association, will be the keynote speaker.

The meeting will open with registration and coffee at 9 a.m. The program will begin at 9:45 a.m. and run until about noon. Luncheon will be served at 1:00 p.m.

Reservations may be made or further information obtained by calling the NJTHA, 2441 Route 22, Union, New Jersey (telephone 687-9340).

Conference on Blindness Prevention

On November 20, 21, and 22, the National Society for the Prevention of Blindness will hold a colloquium on practical aspects of blindness prevention. The meeting will be at the Roosevelt Hotel in New York City. For a full program write to that Society at 79 Madison Avenue in New York (10016).

Conference On The Medical Aspects Of Sports

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association will be held in Miami Beach, at the Hotel Deauville on December 1, 1968. This colloquium will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums on the management of knee injuries, back problems, and problems related to vision in sports. Other sessions will be devoted to a series of clinical concerns in sports warranting increased attention (eg, cauliflower ear, pulled muscles, facial injuries, and communicable disease). One discussion session will be devoted to the controversial issues affecting participation of young athletes, another to health and safety considerations in the conduct of aquatic activities.

The luncheon speaker will be Payton Jordan, Head Coach of the 1968 U.S. Olympic Track and Field Team, who will discuss "The Olympics in Retrospect."

For further information address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Interested In Geriatrics?

If the answer is "yes" put down August 24, 1969 for the eighth world Congress of Gerontology which will be held in Washington, D.C. that week. The sponsor is the World Association of Gerontology, which holds a seminar every three years. The Association is a federation of 34 gerontology societies from 28 countries throughout the world. Professor Nathan W. Shock is President of the Congress, and President-Elect of the International Association of Gerontology.

The program consists of symposia, colloquia, and discussion groups where scientists and professional workers from all over the world can exchange knowledge on gerontologic research and the problems of aging persons. Scientific sessions of short volunteered papers and two plenary sessions are also scheduled. The first will focus on the biologic, psychologic and social theories of aging; the second on health problems of an aging population. Exhibits of pertinent laboratory equipment, apparatus, pharmaceuticals, and books and journals will be on display.

Gerontologists and others working in allied fields may become active members of the Congress by payment of the registration fee of $40. Members of the families of active members, who are not themselves scientists, may register for $20 as affiliate members and participate in social events.

For more information, write to Congress of Gerontology, 9650 Rockville Pike, Bethesda, Maryland 20014.

Cytology Tutorial For Office Practice

Introduction to use of the acridine orange-fluorescence technic, including detection of trichomonas, monilia, yeast, and non-specific inflammations, as well as determination of estrogen and progesterone strengths. Introduction to detection of abnormal cells. Hours arranged. Equipment provided. Fee: $50. Allan Lazar, M.D. 740 Carroll Place, Teaneck, New Jersey 07666. (201) 836-2070

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed

1968

September

5-6 The Academy of Medicine of New Jersey — Section on Obstetrics and Gynecology
Newark City Hospital
Workshop on Culdoscopy

10 Bergen County Medical Society

11 Gloucester County Tuberculosis and Health Association

11 Ocean County Medical Society

16-20 The Academy of Medicine of New Jersey, The American Academy of General Practice, and Newark Beth Israel Hospital
Basic Vectorelectrocardiography

18 The Academy of Medicine of New Jersey
Hoffmann LaRoche Inc.
Nutley
Symposium: "The Moment of Death"

19 Gloucester County Medical Society

19 Morris County Medical Society

24 Hunterdon County Medical Society

30 Cape May County Medical Society

October

1 Hudson County Medical Society

8 Bergen County Medical Society

8 Cumberland County Medical Society

9 Essex County Medical Society
Combined Dinner Meeting with Auxiliary
"Sex Education in the Schools"

9 Gloucester County Tuberculosis and Health Association

9 Middlesex County Medical Society

9 Ocean County Medical Society

15 Warren County Medical Society

17 Gloucester County Medical Society

17 Morris County Medical Society

23 New Jersey Gastroenterology Society
Veterans Administration Hospital
East Orange

23 and 30 The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital
"Coronary Artery Disease"

30 New Jersey Society of Internal Medicine
Hoffmann LaRoche Inc.
Nutley

November

5 Hudson County Medical Society

6 The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital
"Coronary Artery Disease"

12 Bergen County Medical Society

13 The Academy of Medicine of New Jersey
The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 Gloucester County Tuberculosis and Health Association

13 Middlesex County Medical Society

13 Ocean County Medical Society

13 American College of Physicians
New Jersey Regional Meeting
Rutgers University Medical School

14 Essex County Medical Society

20 New Jersey State Dental Society
Semiannual Session

21 Gloucester County Medical Society

21 Morris County Medical Society

25 Cape May County Medical Society

26 Hunterdon County Medical Society

December

3 Hudson County Medical Society

5-6 The Academy of Medicine of New Jersey
Section on Obstetrics and Gynecology
Newark City Hospital
Workshop on Culdoscopy

10 Bergen County Medical Society

10 Cumberland County Medical Society

11 The Academy of Medicine of New Jersey
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

11 Gloucester County Tuberculosis and Health Association

11 Middlesex County Medical Society

11 Ocean County Medical Society

26 Gloucester County Medical Society

26 Morris County Medical Society

1969

January

7 Hudson County Medical Society

8 Gloucester County Tuberculosis and Health Association

8 Middlesex County Medical Society

8 Ocean County Medical Society

14 Bergen County Medical Society

16 Gloucester County Medical Society

16 Morris County Medical Society

22 The Academy of Medicine of New Jersey
Overlook Hospital
Summit
Symposium: "Coronary Care"

27 Cape May County Medical Society

28 Hunderton County Medical Society

February

4 Hudson County Medical Society

11 Bergen County Medical Society

11 Cumberland County Medical Society

12 Gloucester County Tuberculosis and Health Association

12 Middlesex County Medical Society

12 Ocean County Medical Society

18 Warren County Medical Society

19 The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division
Symposium: "What's New in Cancer"

20 Gloucester County Medical Society

20	Morris County Medical Society
March	
4	Hudson County Medical Society
7-9	The Academy of Medicine of New Jersey and Bergen Pines County Hospital Bergen Pines County Hospital Paramus "Current Concepts in Respiratory Disease"
11	Bergen County Medical Society
12	Gloucester County Tuberculosis and Health Association
12	Middlesex County Medical Society
12	Ocean County Medical Society
19	The Academy of Medicine of New Jersey Symposium: "Management of Gastrointestinal Hemorrhage"
20	Gloucester County Medical Society
20	Morris County Medical Society
25	Hunterdon County Medical Society
April	
1	Hudson County Medical Society
2	The Academy of Medicine of New Jersey Symposium on Gynecology
8	Bergen County Medical Society
8	Cumberland County Medical Society
9	Gloucester County Tuberculosis and Health Association
9	Middlesex County Medical Society
9	Ocean County Medical Society
15	Warren County Medical Society
16	The Academy of Medicine of New Jersey Dental Symposium VA Hospital, East Orange
17	Gloucester County Medical Society
17	Morris County Medical Society
26	Kessler Institute of Rehabilitation 20th Anniversary Dinner

OBITUARIES

Dr. Ben W. Berner

At the untimely age of 52, Ben Berner died on April 3, 1968. Dr. Berner was a 1941 graduate of the medical school at the University of Virginia. He was on the attending staff at the Paterson General Hospital, and limited his practice to internal medicine. He was active in the affairs of the Passaic County Medical Society.

Dr. Carl Dvorschak

On the eve of his 46th birthday, Dr. Carl L. Dvorschak died on June 8, 1968 at the Pascack Valley Hospital in Westwood. He was, in fact, an assistant attending internist there. He had received his MD at Marquette in 1951. Dr. Dvorschak was born in Bergen County, and in 1943, at the age of 21, he joined the Army Air Corps. He served throughout World War II and then entered medical school. On being graduated in 1951, he accepted an internship at the Jersey City Medical Center and continued as a resident there. He entered private practice in Hills-

dale and became active in civic and community affairs throughout the county. Thus, he was police and fire surgeon for his borough, a member of the local Board of Health, school physician at Park Ridge, and, in addition to his appointment at Pascack Valley Hospital, on the active staff at Hackensack Hospital.

Dr. Max Friedman

Born in 1905, Dr. Max Friedman died on February 29, 1968 at the age of 63. He was a Trenton obstetrician and gynecologist, doing most of his work at the Helene Fuld Hospital there. A 1931 graduate of the New York Medical College, he was one of the founders of the New Jersey section of the American College of Obstetricians and Gynecologists.

Dr. Joseph C. Hiden

A busy member of the Mercer County Medical Society, Dr. Joseph C. Hiden died on April 8, 1968 at the age of 67. Dr. Hiden received his MD degree at the medical school of the University of Virginia. He early became identified with the Princeton Hospital, becoming an emeritus member of that staff a few years ago, on his retirement. He then moved to Bayhead in Ocean County, where he was living at the time of his death. During World War II, Dr. Hiden was on active duty with the U.S. Navy as a Lieutenant Commander.

Dr. Ernest Larossa

Dr. Ernest Larossa, one of the senior members of the Camden County Medical Society died in Our Lady of Lourdes Hospital there, on June 8, 1968, having suffered a fatal heart attack. Dr. Larossa was 73 years old at the time of his death. He started his professional career as a pharmacist, getting his pharmaceutical degree at Columbia University's College of Pharmacy. He then entered the Hahnemann Medical College in Philadelphia in 1921 and received his MD degree there in 1925. He had two terms (1936-38) as Coroner of Camden County. He was a private practitioner, especially interested and skilled in gynecology.

Dr. Ernst A. May

One of the pioneers in radiology, Dr. Ernst A. May was born in 1892. He was in Feiburg University medical school's distinguished class of 1919, and had an opportunity of working in the field of radiology from its very inception. He was an early member of the American College of Radiology and was one of the first in New Jersey to become a diplomate in that specialty. Dr. May was an active or consulting radiologist at Orange Memorial, Morristown Memorial and Overlook Hospitals. He was a prolific contributor to the literature of roentgenology and radiology. Many of his articles appeared first in this JOURNAL. Dr. May died on May 29, 1968.

Dr. Stanford P. T. Seto

On the eve of his 61st birthday, Dr. Stanford P. T. Seto of Blackwood died on July 2, 1968 after a lengthy illness. Dr. Seto was born in Hawaii in 1907 and received his M.D. from Hahnemann Medical College in 1936. His medical school days in Philadelphia brought him into contact with the people of South Jersey and he elected to make his career in that area. He was on the staff of the West Jersey Hospital in Camden, and was proud to call himself a general practitioner. Dr. Seto served in World War II as a Captain in the Medical Corps and was the recipient of two bronze stars. He was active in civic affairs in Blackwood and the surrounding area.

Dr. Earl R. Symes

Earl Symes received his baccalaureate degree at Columbia University in 1923 and his MD at the College of Physicians and Surgeons there in 1927. He was a general surgeon long identified with the West Hudson Hospital. During World War II, he was a major in the medical corps of the Army of the United States. Although he lived across the river in Kearny, he was active in the affairs of the Essex County Medical Society. Dr. Symes retired from active practice three years ago and died on April 2, 1968 at the age of 66.



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Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. T following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reacti (e.g., blood dyscrasias, jaundice) to phenothiazine Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports o leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within t recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving) Orthostatic hypotension is more common in fema than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess o 300 mg. should be used only in severe neuropsychiatric conditions.

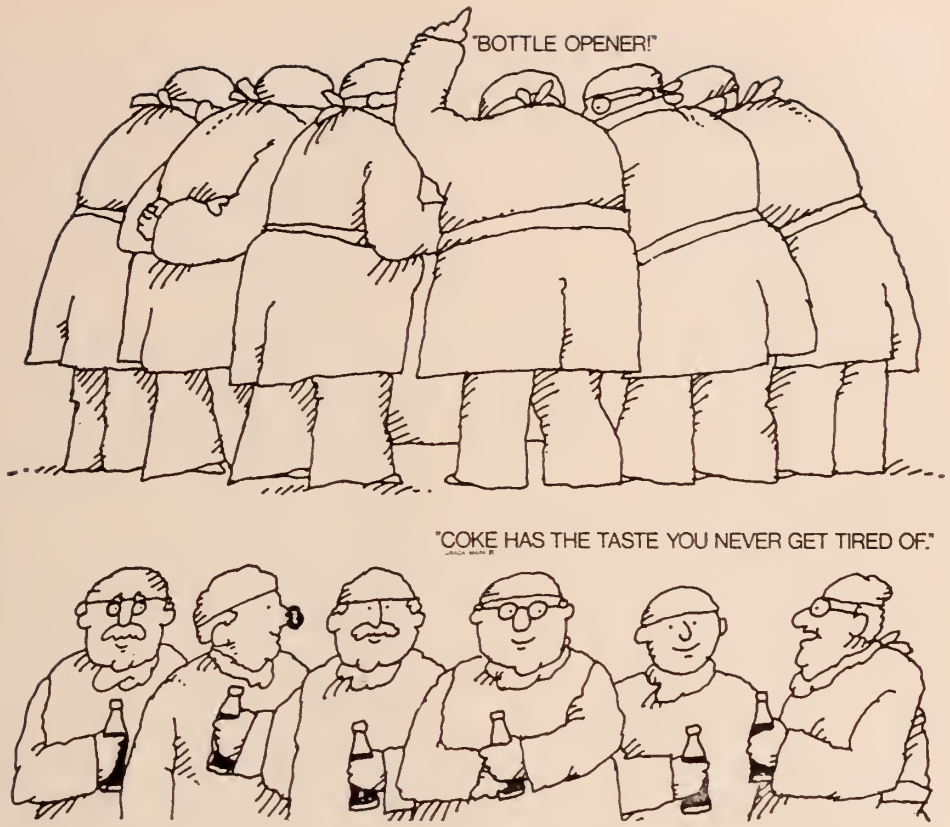
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred visio constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticar type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significa disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arres have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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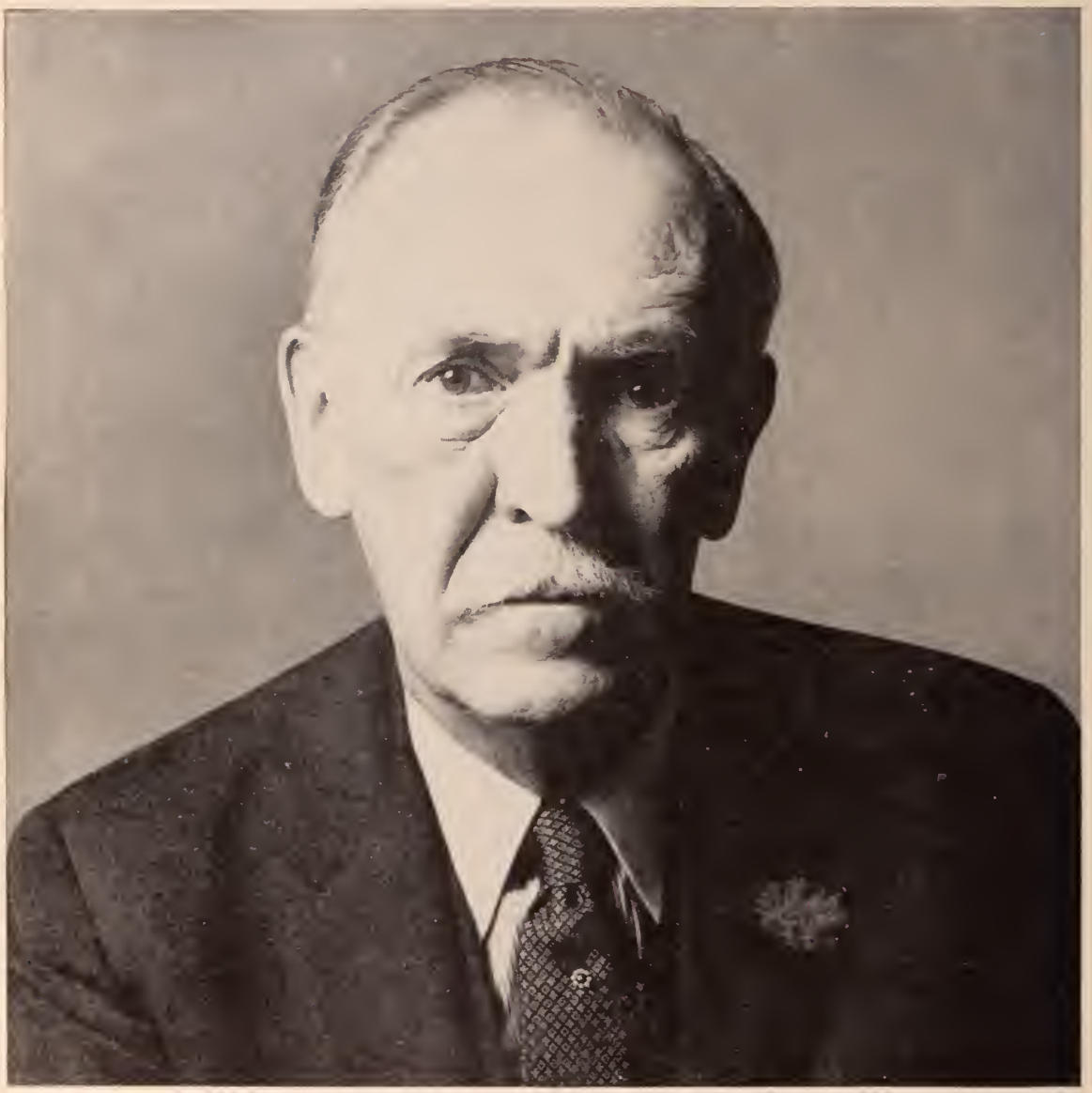
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CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
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Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

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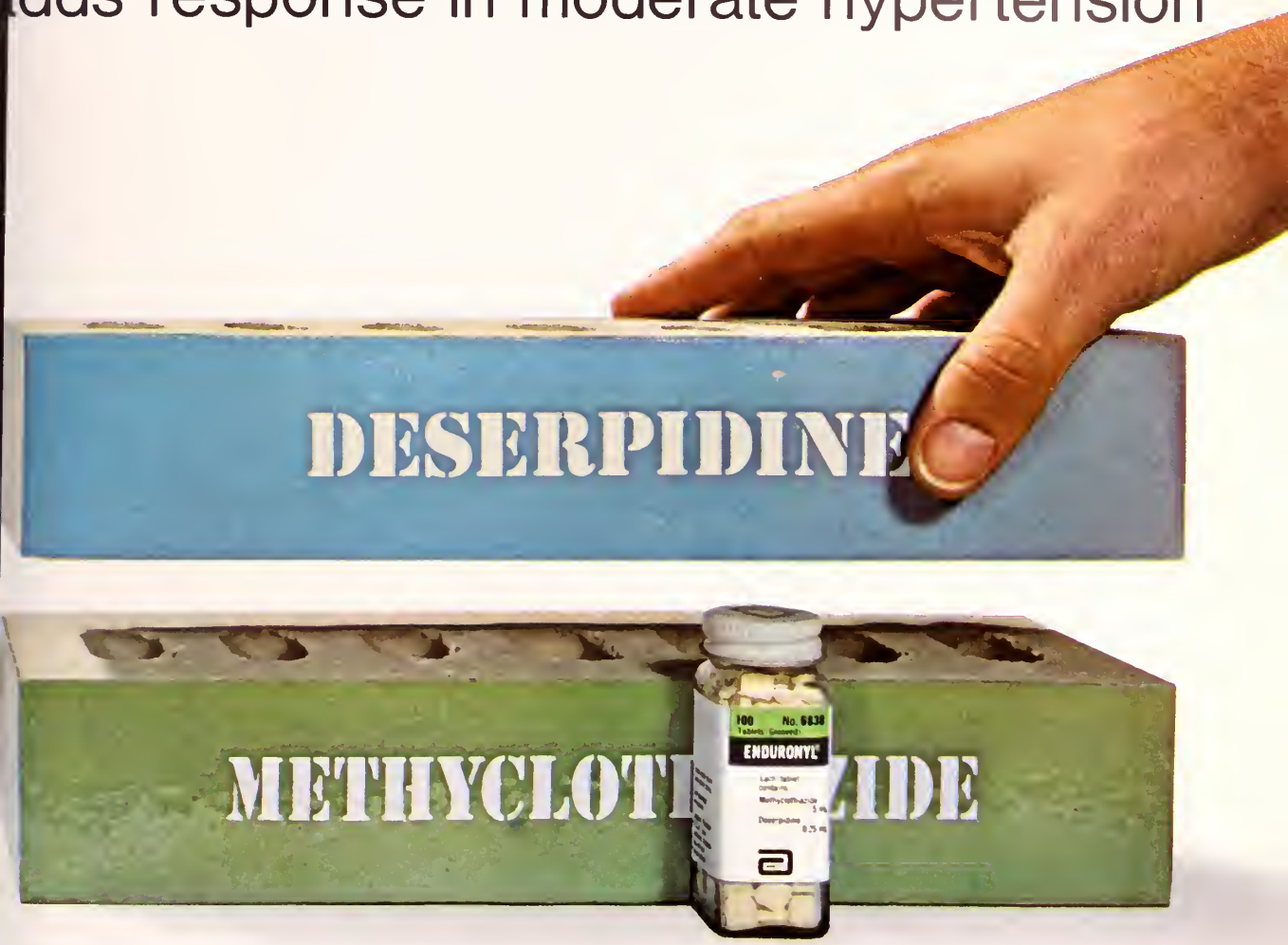
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

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Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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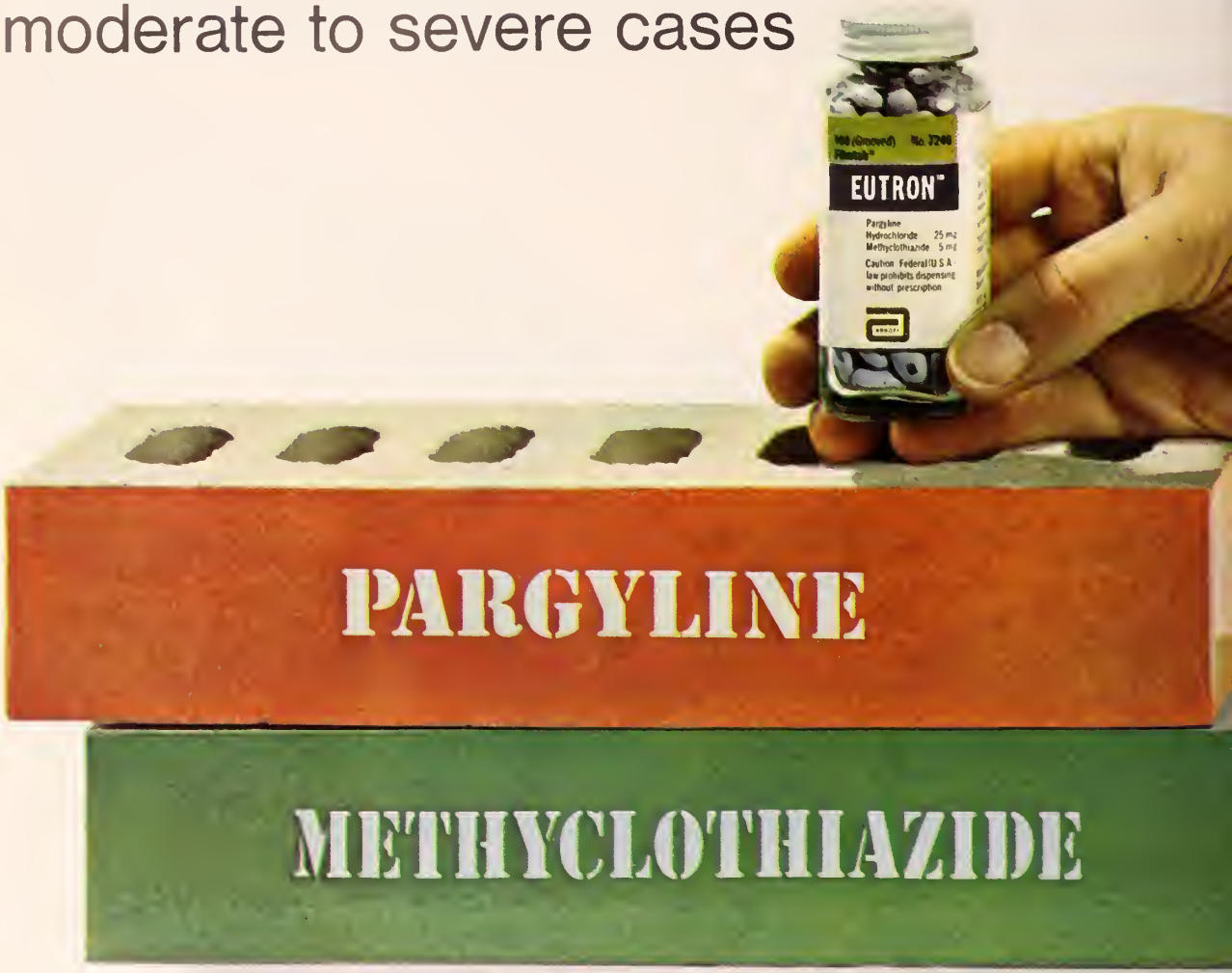
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THYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether yo patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings we reduced from 112 pre-treatment to 90 post-treatment; *sitting* fro 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were near alike in all three body positions.

Use Eutron for managing your moderate to severe cases. I building blocks enhance each other; hence lesser doses often suffic

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVER

See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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SEE PAGE 26A

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EXISTING PRACTICE AVAILABLE—Princeton. For general practitioner and or internist. Office fully equipped. Files up-to-date. Arrangements negotiable. Contact Mrs. Benedict B. Scasserra, R.D. #4, Princeton, New Jersey 08540 or call 609-924-0545.

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This course will be given on 10 consecutive Thursdays. The course is acceptable for 30 hours of Credit by the American Academy of General Practice Category I. Limited registration of 25 students closes September 5, 1968.

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Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

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Adverse Reactions: Side effects most commonly reported drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea; changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

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Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

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SEPTEMBER 1968
VOL. 65, NO. 9

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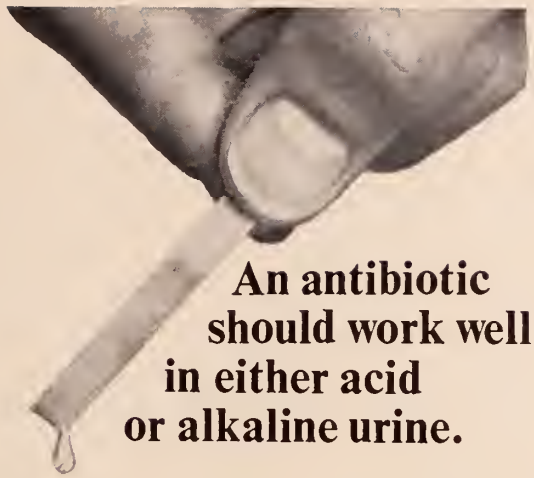
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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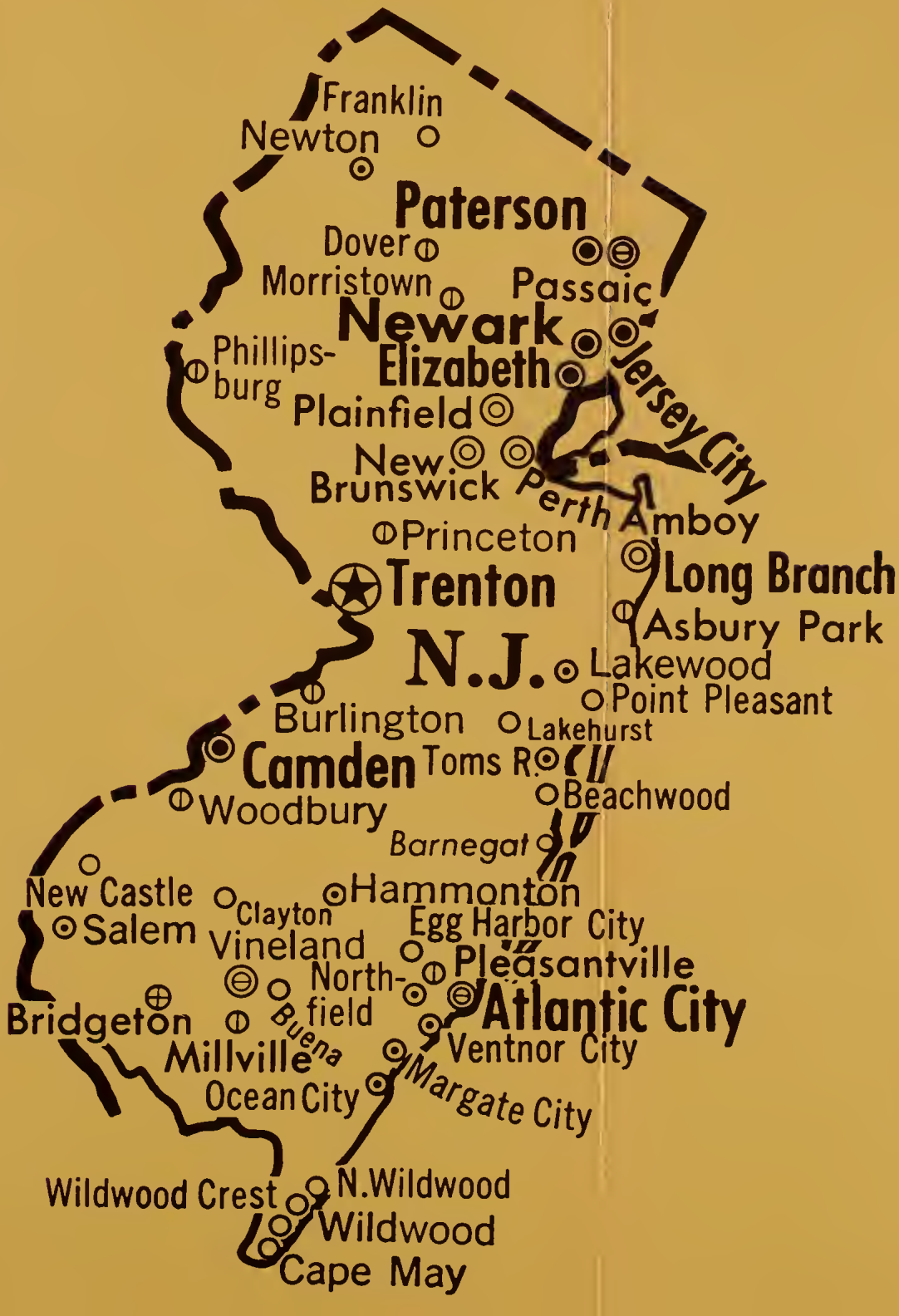
Adverse Reactions: Drowsiness; dry mouth, nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

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Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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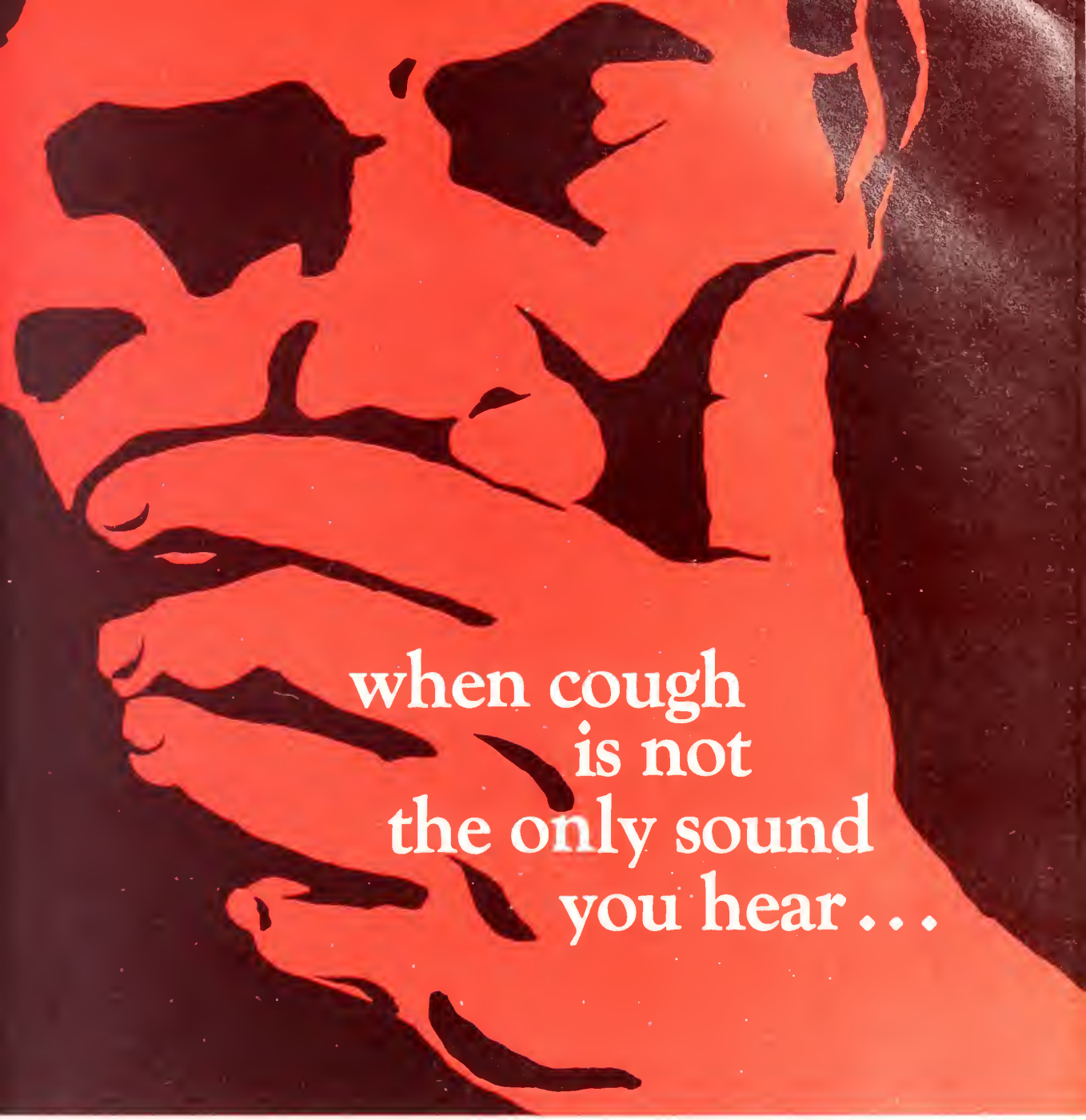
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References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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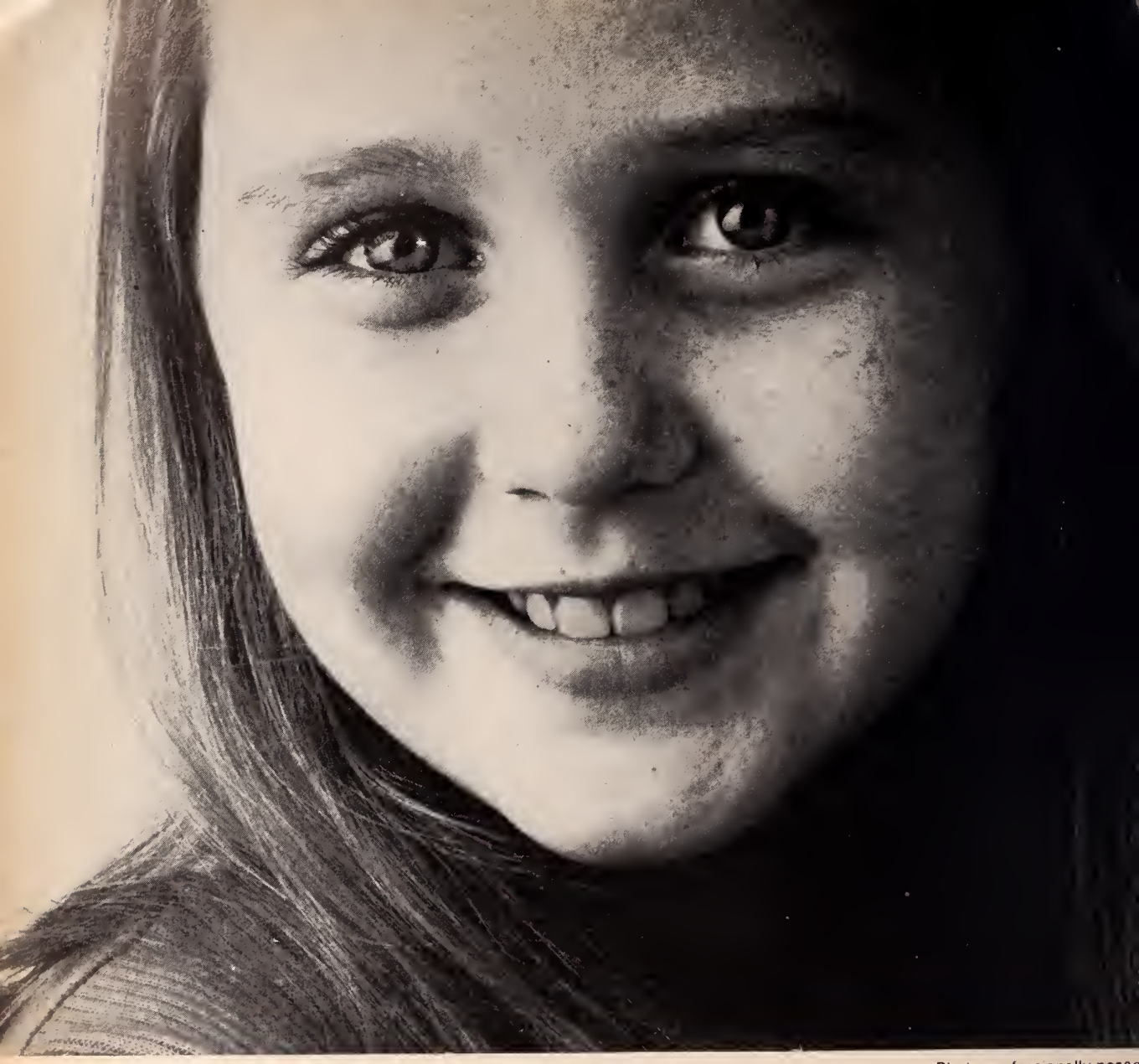


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Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patien sodium excretion is greatly enhanced. Yet potassium loss is lo

The therapeutic action is smooth, and persists for a full 24 hou With Enduron you can prescribe convenient once-a-day dosa without skimping your patients on day-long thiazide effectivene

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

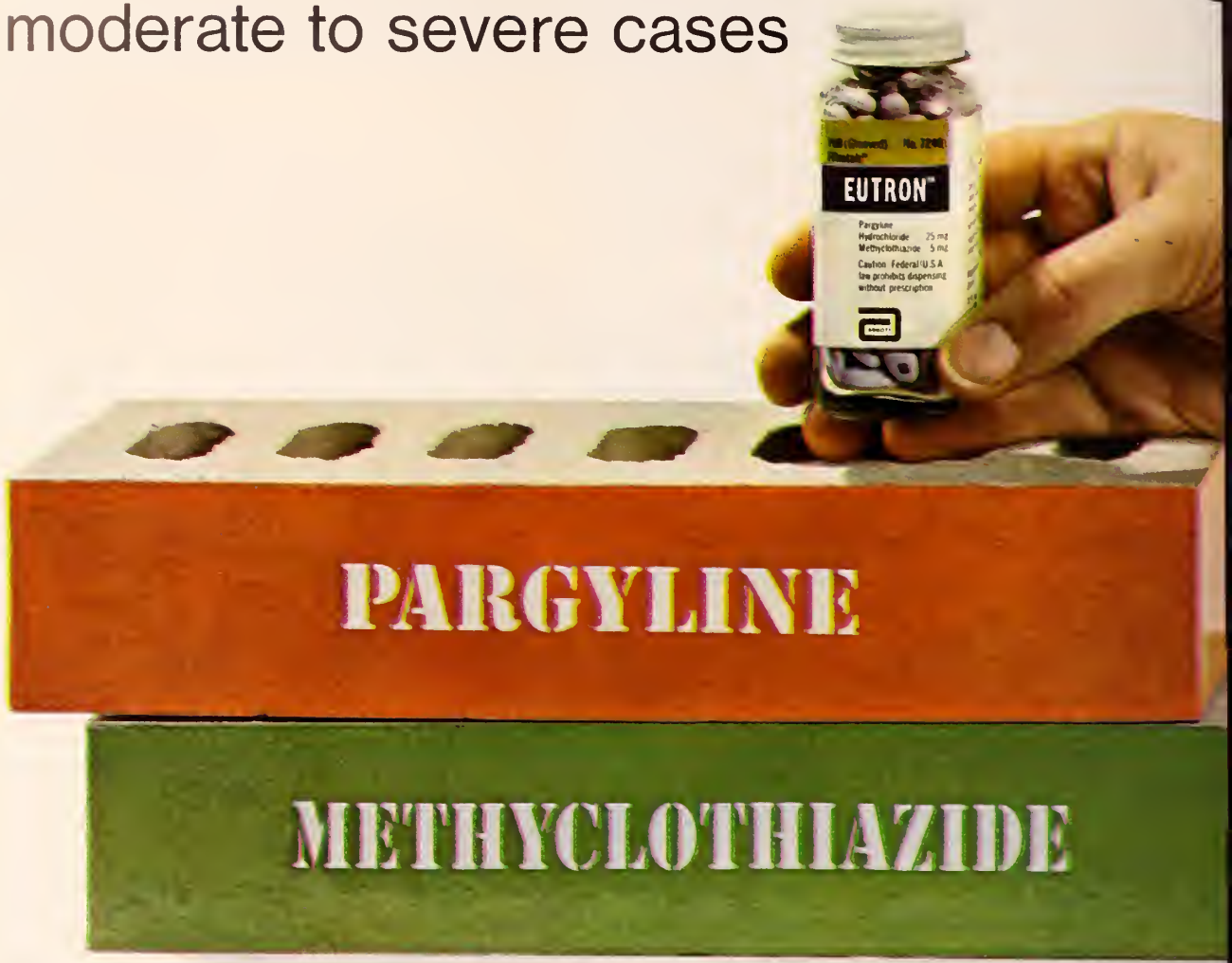
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether you patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

80109

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST
(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
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Director, Nursing Service

THOMAS P. PROUT, JR.
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitols
The Central Inspection Board, American Psychiatric Assn.







when aging brings anguish

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.

Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

THE VALE CHEMICAL COMPANY INC.

VALE

Pharmaceuticals Since 1922

ALLENTOWN, PENNSYLVANIA 18102



BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Diarrhea

TROCINATE® 400 MG.

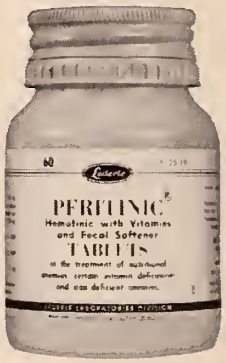
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

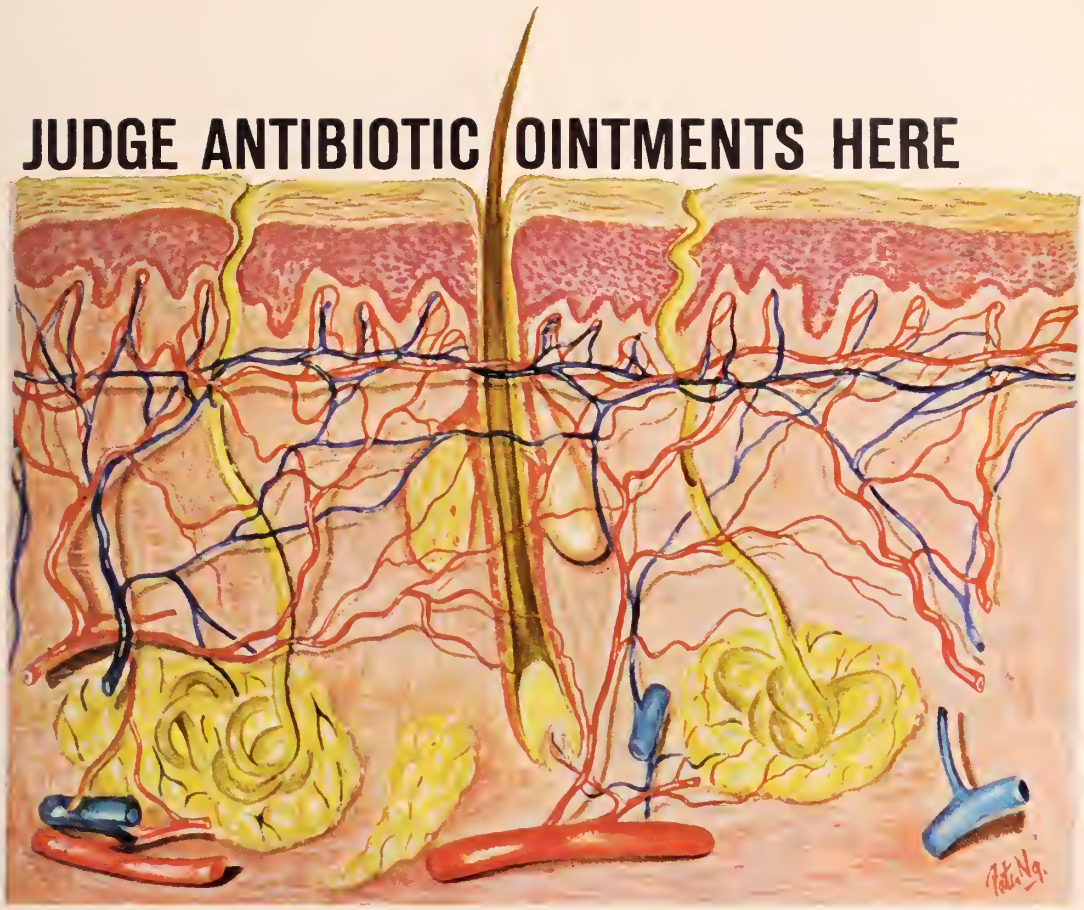
Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.


Muscle in Spasm

and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Louie lost weeks with
a painful shoulder. That's a lot of fish.
It might have been different with **Butazolidin®** al

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

If it doesn't work in a week, forge

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)R 46-070-A

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

BU-5926

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains 15% alcohol†)
†Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound

Ayerst®

AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada 6837

Is it depression?
He says "It's my stomach..."



...but his other symptoms:
functional somatic complaints, anxiety insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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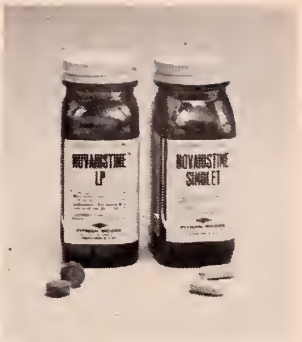
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EDITORIALS

Medical Education For The 21st Century

Maybe it will be different this year, but too often physicians' presidential votes correlated badly with those of the general public. We like to take comfort in the thesis that doctors are better educated than the general public, and therefore *our* political views represent those of an intellectual elite if not those of the public. However, college teachers, psychologists, sociologists, and similar groups come closer to the public's voting pattern . . . and they represent a well-educated group too. Ceithaml's report[1] shows that 30 per cent of medical students these days come from families with incomes in excess of $15,000, whereas, nationwide only 5 per cent of American families fall in that bracket. That is (with some exceptions, of course) physicians seem to be recruited disproportionately from families that are not "typical." Using a simple three-part breakdown, Rosinski[2] showed that the top 3 per cent of the population (tops in social-economic status) supplied 33 per cent of the medical students. This imbalance has two unfortunate implications. First, it suggests that we come largely from a skewed sample of the population; and second, we are a group which doesn't like to see anyone rock the boat in which we are riding so smoothly.

In a sense, medical school represents a vocationally-oriented education with heavy demands for technical knowledge, scientific skills, marked by a learning that is deep rather than broad. Indeed, so burdensome are these demands, that the average medical student does not have time to develop a feel for man's social institutions and personal philosophies. For many, this leads to an alienation from what used to be called "the humanities." It is a strange irony that our profession, whose proper study is surely man, should by reason of our training be too much cut off from man in the abstract because of his microscopic concern with the man before him.

It has been suggested by one writer that the patient often feels that the physician has become dehumanized, causing the public to identify the profession as a group responsive to a different social ethic. One solution to this, suggests Swartz[3], is to have the student get a broadly based "liberal" education in college, majoring in medicine (not in biology or chemistry), with the MD being awarded after graduate study plus an interneship. The experimental program at John Hopkins is cited by Swartz[3] in these terms:

> A case in point is the experimental program at Johns Hopkins, described in Turner's *Fundamentals of Medical Education,* in which a limited number of students enter the School of Medicine after only two years of undergraduate work. Medical school lasts five years, during the first of which physics, two humanities or social studies subjects, chemistry, mathematics, and genetics are studied. The second year, which includes at least one more course in the liberal arts or social sciences, leads to a bachelor of arts degree. Curricula for the remaining three years are devoted solely to medical subjects, the last of which is a 12-month internship.
>
> While this approach seems to me worthwhile, the physician is expected to be an intellectually bigger person than such a modest revision in curriculum is likely to produce. The earlier enrollment in medical school should be supplemented by an earlier beginning of undergraduate work.

One implicit but questionable assumption in all this is that you can teach a social ethic through college courses, or hand out "liberal arts" wisdom in a classroom. It cuts deeper than that. It is a reflection of the basic war between the creative artist and the technologist. Modern medical and surgical practices are becoming entangled in wonderful technologies—technical advances that save lives. The trouble is that the people who program them have to be technologists. Suppose we do get that wonderful computer that will spew forth a diagnosis when you punch in the symptom, and will accordingly print out a treatment regime when you feed in the diagnosis; and will then administer the actual treatment with needles, nasal tubes, and monitors that switch on lights and ring bells—sup-

1. Ceithaml: *Journal of Medical Education,* June 1965
2. Rosinski, Edwin: *J.A.M.A.,* June 12, 1965
3. Swartz, Harry: *Medical Opinion and Review,* (1:47) November 1965.

pose we get them. What then will be the role of the physician? It's something like the dilemma of the atomic scientist. Does he or does he not have any concern with the uses of atomic energy? Is he only a technician with no involvement in the ethical, spiritual, or humanitarian aspects of atomic energy? And what is the doctor of medicine? A technician or a socially involved citizen with a deep commitment to humanitarian principles and "the humanities?"

Science is wonderful, and it can be taught in the laboratory, the library, and the classroom. But a social ethic, a "wisdom," cannot be passed on so easily. Almost every entering medical student this fall will do most of his practice in the twenty-first century!

The Medical Flavor Of Medical Meetings

Like most of us, we get around to a number of medical meetings every year — County, State, other states, AMA, and our various specialty groups. We have been noticing since World War II (but there is no connection here) that less and less of the meeting time is being devoted to scientific and professional programs. Not only less time, but less interest, too. So we felt like saying "Amen" to an item by Irvine H. Page, M.D. in the June 17, 1968 issue of *Modern Medicine*. Here are excerpts from this choice bit of modern medical Americana:

"I will gently point out that medical meetings should return to being medical meetings. This is an odd statement you will readily admit, but I think you will agree with it. I fear that commerical exhibits, women's auxiliaries, door prizes, committee meetings, golf tournaments, breakfasts, delegate meetings, shopping, and shows and such like are downgrading the intellectual content of of our professsional meetings. Unless the subject is sex, most speakers draw token attendance. Too often the members only read in the newspapers what was presumably presented at the meeting. The scientific program is something to be endured rather than savored. Speakers seldom do their best in such an atmosphere of indifference.

"There are, of course, many meetings in which this is not true, but these are usually the small ones and largely for specialists or academicians. This is more the pity because it is the bulk of physicians confronted with the multiple problems of medicine who need stimulation and education most: for example, those who attend chiefly the state society meetings where too often the intellectual content is adequate but boredom is as plain as the dozes on their faces.

"Physicians' wives enjoy the activities of the auxiliaries, and pharmaceutical manufacturers need a place to exhibit their wares. But in all the hubbub, the speaker's message is lost. He is becoming something to be tolerated, a holdover from a vanishing milieu. If the 'medium is the message,' the human form is becoming obsolete.

"There are many minor things to find fault with, but the important thing is to restore the principal reason for a medical meeting. This can be done simply if we all give it a little thought. If we continue the practice of allowing the public to take over the exhibits, the hospitality committee to keep everyone up too late, and committees and golf to monopolize the time of the members, then let's not try to save face by going through the motions of holding scientific sessions.

"This is no exaggeration, because many meetings are getting perilously close to just this. I fully recognize the need of some to carry on the business of the society, though most of it should have been done before the convention. But the mechanics should be kept in proper perspective. We must restore the interest, dignity and vitality of the intellectual content of our professional societies."

Is it too late to do better? Now would seem like a good time to do our programing for next year. And let doctors—not computers—do the programing.

ORIGINAL ARTICLES

We are all our fathers' keepers—and when father or mother becomes confused, stubborn, or irritable, it is time for patience, scrupulous weighing of the inventory of available medications, and a practical application of the Fifth Commandment.

Geriatric Psychiatry*

J. Lloyd Morrow, M.D./Passaic

Aging is a term to describe the processes of biologic, psychologic, and sociologic change from one point of time to another. Our population is getting older; more people are living longer. Three-fourths of the non-institutional population aged 65 or older have one or more chronic conditions. Almost two out of five have a chronic condition that puts some limit on activity. The most prevalent diseases of the aged are cardiac, cerebral and arterial disease, mental and "nervous" disorders, cancer, and diseases of the joints. Where these are accompanied by disability or invalidism, they may take a heavy toll of the resources of the patient, the family, and the community. Viewed in terms of chronic condition, the process of aging would seem to lead inevitably toward debility, dependence, and despair. Redefined in terms of capacity to function physically, mentally, and socially, we can visualize great resources for adaptation and great potential for independent and happy living.

Aging occurs differently in terms of body changes not only between different people, but in different systems of the same individual. To be sure, there are modifications with aging in the body's resiliency and power of adaptation and in its ability to function well under strain. People can reach extreme old age, however, in perfect health, with no evidence of earlier disease—provided they began with a favorable genetic endowment and lived in a favorable environment. Many others bear the scars of earlier disease and deprivation. There is a wide range of effectiveness among the aged, as in people in general. Superior people excel in old age as they did in youth, Mediocrity in youth does not improve with aging.

Some 95 per cent of persons aged 65 or more live in the community. The proportion of persons 65 or over who live in nursing homes, homes for the aged, and mental institutions is about 5 per cent. Most of the elderly live in their own homes, look after themselves, and manage their own resources. Those with children prefer to live apart from them, but close enough to be seen often by at least one and perhaps all of their children. Intelligence, learning ability, and other skills hold up remarkably well until a major breakdown in health occurs. We have come to take for granted the three generation family. Now we are seeing an increase of four generation families with two generations over age 60 or 65. These include 60 or 65 year old children of parents who are in the 80's. In these situations, the pattern of dominance is often child-parent rather than parent-child. The 65 year old may face divided loyalties to his parents and to his children.

There is still a great deal that we need to know about the biologic, behavioral, and social manifestations of aging. It is still a matter of speculation whether there exists a biologic process fundamental to the manifestations of aging. So many changes come with age to so many people that the changes can hardly be termed abnormalities. We must content ourselves at present with the thesis that: "Since

* Presented February 15, 1968 in lecture series at Essex County Overbrook Hospital, Cedar Grove, New Jersey. Dr. Morrow is Director of Psychiatry at Passaic General Hospital and Clinical Associate Professor of Psychiatry at the New Jersey College of Medicine and Dentistry.

the essential property of the living system is its ability to maintain, repair, and reconstitute itself, the aging process presumably involves a decrease in the efficiency of the mechanisms for reconstruction."[1] Aging has been thought of as producing vulnerability to stresses. These may be disease, accident, or psychosocial events, such as widowhood, economic deprivation, and loss of status. It may be that our oldest people are extraordinary survivors of stress because of genetic endowment, acquired abilities, or luck.

In the last two centuries, the indigent elderly have been sent to hospitals, workhouses, and asylums. This is one effect of social factors which include industrialization, urbanization, the consequent changes in the family, the attitudes of the community to poverty, the philosophy of economy and centralization in administration, and the availability of custodial facilities. The aged were often thrust aside, socially isolated and alienated. There is some promise of reversal of this trend in the United States, since the recognition of the problem of the increasing aging population. Today, almost one in ten Americans is 65 or older, about 19 million persons.[2] By 1975, there will be 22 million aged, and more if breakthroughs occur in treatment or prevention of cancer and cardiovascular-renal disease. By 2000, at least 30 million will be 65 or older. About 6 million of today's 19 million aged are over 70 and this one in three proportion will grow. By 2000, we will have as many people over 75 as we had over 65 in 1950. More aged means more chronic disease. This means a need for more physicians' services, drugs, hospital admissions, and custodial services. Medicare alone is a vast operation and about one-fifth of all U.S. spending for health care is for the elderly. In 1960, combined public and private expenditures for medical care of the aged reached $5 billion.

From an operational point of view, the term *geriatric psychiatry* is an unfortunate one. There is an unmistakable social resistance to facing the facts of chronic disease based upon hopelessness, problems of dependency, aesthetic offensiveness, old resentments and guilts, and the universal evidence that the social status of the aged person in our society is certainly not at the top of the list. The internist or family doctor is mainly responsible for the care of the elderly in the United States. The psychiatrist is called when mental, emotional, and characterologic changes require specialized help on emergency, custodial, or medicolegal bases. The general physician has an aversion to the care of "old crocks." The family has an aversion to the necessity of calling him. Hospitals have never welcomed the elderly. Some of this is being remedied by the rewards of Medicare and prepaid insurance today, but basic aversions are unchanged. Psychiatrists have displayed similar disinterest in the aged — probably for the same reasons, and undoubtedly because of rationalized preconceptions that one can do little with deteriorated ego states and irreversible organic psychotics. The term "Geriatric Psychiatry" has attracted few adherents in terms of practice or research, yet the demands increase daily.

Notwithstanding these facts, more and more psychiatrists are treating emotional and behavioral disorders of the aged in homes, offices, and hospitals. A separate specialty of Geriatry, as one writer labels it, or "psychogeriatrics," is unnecessary. This designation may have a particular attraction to some physicians interested in problems of the aged and, as such, may have some utility, especially in learning methods of working with other professions, such as nurses, social workers, dentists, therapists, nutritionists, podiatrists, and psychologists. There is even a School for Geriatry at Duke University. Many centers are giving instruction in this field. Medical treatment is not enough. Physical, psychologic, and social factors must be considered in caring for the elderly patient whose problems are multiple, rather than singular. Treatment must be person-oriented, rather than symptomatic, given with purpose and hope, tailored to the individual's strengths and weaknesses without expecting too much or too little and, finally, with reliance on an integrated team approach, using the full range of community services.

The aging person has diminishing capacity to adapt to stress. He is less able to regulate pulse rate, blood pressure, blood glucose level, blood pH, and oxygen consumption rate than the younger individual subjected to the same environmental stresses. The elderly also demonstrate increased vulnerability to temperature changes. Total body heat production falls and capacity for heat regulation decreases. After brief exercise, the recovery time for carbon dioxide elimination and pulse rate is increased in older subjects. The reduced adrenocortical response to stress may be due to decreased stimulation from the hypothalmic-hypophyseal centers. Bodily and psychologic changes occur under the stress of infectious diseases, trauma, including surgery, and emotional conflict and crisis. What is not generally known is that an older patient can recover from an acute illness almost as rapidly as a younger person, assuming he is otherwise in good health and is normally motivated. Given a good blood supply and the proper state of nutrition, the older person's tissues heal well. Mental changes in old age frequently are related to physical disease and often are reversible when the physical cause is relieved. Because this is so often the case, when mental changes occur in the elderly, it is best to assume that there is a physical explanation for these changes, until this assumption has been disproved. This is doubly likely, the more recent and unexpected the mental change.[2]

Emotional stress and disease are only part of the threat to the well being of the aged patient. Inactivity, dependency, and depression (not due to disease but to just growing old) commonly cause symptoms which we are accustomed to see as structured neurotic and psychophysiologic reactions. Chronic stress of this type is associated most frequently with skeletal muscular disorders with hyperreflexia, clonus, muscular fatigue and facial tics (which, some say, come from little strokes.) Cardiovascular complaints, such as precordial pressure and pain, palpitation, throbbing, and tachycardia are manifestations of anxiety and may predispose to coronary occlusion and stroke. Gastrointestinal complaints, such as nausea, anorexia, vomiting, and diarrhea, are very common. Rheumatic arthritis, asthma, chronic ulcerative colitis, obesity, and enuresis are other well known concomitants of emotional stress.

In my review of the literature, I have not seen a singe article devoted exclusively to a study of the neuroses of the aged. Most writers agree that mental and emotional disorders of the elderly must take into consideration the physiologic changes of senescence with emphasis on changes in perception, especially hearing and vision. One author[6] views the hypochrondriasis of the aged as reality-based, as a means of defense against anxiety and an attempt to solicit sympathy, forgiveness, and help. The same author[6] describes some depressive reactions as similar to grief in younger people, with the superimposition of feelings of self-blame and, in others, of blame projected to others in the form of feeling rejected and neglected. There is a general consensus that psychoneurosis in the elderly stems from previously compensated psychoneuroses, touched off by new stresses.

My experiences in a fairly long exposure to aging and elderly patients in the private practice of psychiatry in office and general hospitals, would confirm the belief that old neuroses never die, nor indeed fade away, that old age does not ameliorate chronic psychotic states or tend to diminish the recurrence of psychotic episodes. There is an unquestionable tendency to the re-enforcement and hardening of certain characterologic traits, such as hysterical responses, obsessive-compulsive patterns and paranoid thinking. I have never seen mentally or emotionally ill elderly patients who have attained the Shangri-La of serendipity. However, there is a difference in these patients from the younger and middle aged groups which one is tempted to ascribe to organicity in terms of pathologic changes in cognitive function, memory, attention, and interest. While these changes are undoubtedly present to some degree in the aging process, there is observed in early and late aging persons a recurring theme of mourning for a fading past life and

increased awareness of the inevitability of death. This is augmented by the social conditions already mentioned. It derives more directly, however, from increasing ego weakening, making the instinctual drives more difficult to handle. These, in turn, are either converted by the ego into suitable symbolic substitutes, as in all neuroses, or fragment the ego with the production of suitable substitutes for the unbearable reality, as in psychosis.

Numerous cases can be cited to bear out these observations, of which I will mention only a few. Mr. A was 60 when I first saw him for a depression, after he had a coronary attack, following a fire in his store. He was of typical "cyclothymic" personality. His predominant compaint was that he could no longer smile at his customers or, indeed, want to make sales any more. He was carried in psychotherapy over a year, principally on a dependency relationship. He came accompanied by a woman companion, twenty years his junior. Death fears were freely ventilated and associated with his wife's failing health and his giving some of his stores and money to his sons. When his wife died, he mourned briefly, then married the younger companion, who was of another faith and brought him home to live with her and her aged mother. After the age of 65, he sired two children, went into a new business (which he established for his new wife), had a recurrence of his depression and, after recovery, went to the horse races and dropped dead. This man, in denying his death fears and his condition, was his own executioner.

A good example of a rather typical syndrome is Mr. B who was seen at 73 for a severe borderline agitated depression which he had suffered recurrently for ten years, beginning one year prior to mandatory retirement. Cases of pre-retirement anxiety are common in my practice. Always a compulsive conscientious worker, he had risen to a fairly high position. To him, retirement was a symbolic death. He had a marked fear of leaving his house, trial of which would bring on a Menière-like reaction, and he was treated for this until a severe attack on his first day of a trip to Florida for which he was brought home. He has been treated successfuly over the past eight months, in triangular sessions with his aged, adhesive wife. Death fears have been appropriately discussed and integrated into a total context of health.

"Death fears" make up a syndrome in which such fears represent an end-of-the-line type of threat at this age period, partly because, in a sense, it is that, and because neurotic and psychotic states are alternatives to being able either to correct and improve the situation or to accept it. It is also an indictment of a society that does not permit man to chose when he will terminate his work, and the associated feelings of worth and self-esteem that go with it. To an older person with a breadth of experience, viewpoint, and a depth of understanding, retirement is a crowning insult. To his nonemployed wife, it means reorganization, readjustment and also an awareness of the imminence of the end. Each partner, on his own, makes his neurotic compromise.

However, the vulnerability to impairment of mental functioning and the physical and sensorimotor deficits of aging, with varying circumstances and situations, do lead to limitations of overall functioning. The aged are sensitive to failing performance or shifts of status. It is common to encounter from this a fear of death, loneliness, uselessness, and changes of body image and self concept. Among the social changes they face are death of friends and loved ones, revision of their roles with children and younger colleagues as well as peers. Some try to compensate by counter-phobic measures and endanger themselves. Others avoid new situations and give the impression of being rigid and conservative. They usually report some memory deficit, particularly for recent events, and are inclined to dwell on the remote past. Forced into new or puzzling situations or tasks requiring abstraction, they respond with anxiety, irritation, or withdrawal. Many become egocentric, possessive, and concerned with their health. On this soil, and in reaction to new stresses, arise the behavioral problems which confront the physician. Previously compensated neuroses and sociopathic

tendencies may then flare up, or we may be confronted by the severe behavioral disorders.

The aged are becoming a greater proportion of our hospital populations, both in reaction to our increasing aging population, and to the social reasons above outlined. There are vast numbers of senile and arteriosclerotic psychotics in general hospitals, nursing homes and homes for the aged, and in all modalities of care, both medical and psychiatric. A recent article[7] raises the question of whether nursing home care is superior to hospitalization, at least in California. One is particularly impressed, however, in the general practice of psychiatry, that when an elderly psychotic is regulated behaviorally, even the most reluctant of relatives will accept some degree of responsibility for home care to the very end, making the most improbable readjustments and compromises, if some degree of community help is available as through clinics, physicians, nurses, social workers, and the clergy. Hospitalization is too often a measure born of desperation and misinformation, aided and abetted by poverty and helplessness.

Senile psychoses run about a third of all first admissions to mental hospitals and remain about a sixth of the total patient population.[3] Psychoses with cerebral arteriosclerosis account for up to 40 per cent of first admissions but their duration of stay is somewhat different.

I have found useful the four-fold clinical classification of senile psychoses: (1) Simple deterioration (senile dementia) which includes presbyophenia; (2) Paranoid; (3) Affective and (4) Delirious and confused reactions. The chief utility of this classification is for psychopharmacologic purposes and differentiation principally from the predominatly vascular states, psychoses with cerebral arteriosclerosis.

Simple Deterioration (Senile Dementia), representing about 58 per cent, may develop slowly or rapidly leading to total incapacity and helplessness. Often this results from situational stress or change (job loss, forced retirement). At the beginning, we may see forgetfulness, failures, lack of judgment, silliness in opinion and conversation, and inability to perform abstract tasks. As the process progresses, the patient is unable to carry out even very simple tasks and requires constant supervision. Memory for recent events is nil and he may confabulate to cover up or deny his deficit (Korsakof Syndrome). Patients with simple deterioration also develop striking emotional changes. Catastrophic anxiety reactions occur and some are in a constant and restless state of agitation (presbyophrenia). The most common reaction is depression and apathy, but a small minority become hostile and aggressive and subside fairly readily with reassurance against paranoid fears. Many senile temper tantrums are responses to provocations. The patient, unable to test reality, may realize dimly that he is unwanted and develop delusions that others are stealing his belongings or food. Some women patients believe that men are sexually interested in them. Old men may become involved in sexual misdemeanors with little girls. The children incidentally, may be the provocateurs.

Paranoid Reactions, representing 15.75 per cent, occur in brief flurries often associated with deficits of sight and hearing. Lifelong paranoid personalities and sociopaths tend to get worse with old age. Paranoid schizophrenics may improve.

Affective Disorders representing 7 per cent, may be mild to severe, brief or permanent, and have the characteristics of psychotic depressions. This represents the profound resignation and indignation of a deeply wounded person who feels unloved, unwanted, and abandoned. There may be some expressions of irrascibility and guilt over past sins and failures. When provoked, they may become quite agitated and destructive. The statistical likelihood of suicide in old age is high. Even mildly depressed aged patients frequently make suicidal attempts or show self-destructive behavior.

Delirious and Confused Reactions represent about 18.5 per cent. Even a slight cerebral deficit very markedly increases the chance of

disorientation and confusion. Confused states are common in patients with cerebral arteriosclerosis and in convulsive disorders. Confused states are frequently seen at night or when patients change environments or undergo operations with general anesthesia. Ophthamologic operations with post-operative blindfolding are a particular hazard.

The diagnosis of chronic brain syndrome associated with cerebrovascular disease, psychotic or not, must be based upon demonstrable evidence of pathology in the cerebral vessels, such as vascular retinopathy and cerebral accidents. People over 60 have a certain degree of general and cerebral artiosclerosis and we must be reasonably sure that the so-called general "psychiatric" symptoms — irritability, mild depression, and apathy — are caused by vascular brain disease. Vascular changes, in contrast to senile deterioration, are amenable to treatment. In early stages, deterioration is slight and complaints of headaches, vertigo, memory failure, with good insight, may be only episodic. Mild hypertension produces transient twilight states, and a syndrome of repressed hostility, dependency, mild judgmental defects, insomnia, loss of energy, and anxiety. Severe hypertension produces the well known physical and confusional crises.

The *acute* type occurs in more than half the cases. It is often associated with gross neurologic disturbances, with clouding of consciousness, loss of contact, incoherence, restlessness, and hallucinations. In the cases of *slower onset,* one sees impaired attention and concentration, loss of associative capacity, retrograde amnesia, perserveration of ideas and words, and regressive withdrawal. With the production of agnosia, aphasia, and apraxia, the train of thought is completely fragmented. A spotty sensorium with fluctuations of memory is the rule, and it is not infrequent in the course of the disease to witness an unexpected return of the memory for variable duration. Personality changes depend on the prepsychotic personality as well as on the intensity of the vascular insult. Moral and ethical conduct are especially vulnerable to change. Confusional states occur in about one-third of the cases, varying from slight clouding and apprehension through episodes of violence not unlike those in seizure states. Differentiation from senile prodromal signs, confusional reactions, memory impairment, judgment defects, and prognosis is thus based on a preponderance of vascular and neurologic symptoms in cerebral arteriosclerotics. Other problems of differentiation occur when both conditions co-exist and when there are other conditions present such as chronic schizophrenia, alcoholic deterioration, general paresis, or exogenous toxic deliria.

Diagnostic criteria are the basis for the management of psychiatric syndromes of the aged. Most mental changes in the aged are related to physical disease. This is especially true when the mental change occurred quite suddenly. This is important in the evaluation of the aged patient where a state of senile deterioration can be improved or ameliorated for a time by good physical care. Proper diagnosis is doubly important with arteriosclerotic psychotics where clinical remissions are often encountered, especially at onset.

Average duration of stay of cerebral arteriosclerotics in mental hospitals is 3.5 years. Death occurred in 61 out of 100 consecutively admitted such patients within one to two years from date of admission to hospital, the majority (42), dying within three months. Prior to admission, 39 had a duration of psychosis of less than six months and 27 of these 39 had a duration of less than two months. But, it must be emphasized that while brain damage and dysfunction can be deduced from the observation of behavior, the absence of cerebral impairment cannot be established by behavioral observation alone. This can only be done through the total clinical context of the history and physical and laboratory findings, in addition to the positive presence of particular patterns of behavior.

From a psychosocial-dispositional viewpoint, one must answer the following questions:[4]

(1) Is the patient intellectually deteriorated? To what extent? Clinical examination and psychological tests will answer these questions.

(2) What is the type of the disorder and how severe is it? Is the patient depressed or agitated? Paranoid? Confused and delirious? Is his behavior essentially a continuation, exaggeration, or rearrangement of lifelong neurotic or sociopathic traits? A thorough history and examination will furnish the necessary data and will also establish the patient's role in his family and community.

(3) Is the patient's behavior difficulty complicated or caused by organic illness or injuries? Does he suffer from vascular brain disease which can be treated? Are there sensory or preceptual impairments (often amenable to repair and/or rehabilitation)? This will determine whether other specialists can help.

(4) To what extent is the patient's abnormal behavior a response to interpersonal difficulties in his family, occupation, or community? Most of the milder and more transitory maladjustments of the aged may be explained on this basis.

(5) How does the patient's suffering affect other persons in his family or natural environment? To what extent does he depend on social and medical care? To what degree can persons in his environment be realistically expected to cope with his difficulties? Is the person dangerous to himself? To others? Fortunately, aggressive and sexual crimes by senile persons are rare, but considerable harm may come from their defective judgment; hostile impulses of which the patient may be utterly unaware, of course, may play a role when senile persons set fires, drop babies, cause traffic accidents, or injure themselves.

One cannot leave the subject of disposition without reference to the matter of wills. Davidson[5] summarizes the problem: Testamentary capacity depends on the person making the will having the ability to: (a) know that he is making a will; (b) know the nature and extent of his property and (c) to identify the "natural objects of his bounty." The subject is also well summarized in the Medicolegal Almanac of the New Jersey Neuropsychiatric Association. The matter of the testamentary capacity of the aged is of the greatest importance and proper diagnosis and assessment of psychotic states in the elderly are the cornerstones on which decisions must be founded.

These people are best treated by psychiatrists with training and experience in supervising and collaboration with ancillary workers such as general practitioner's, social workers, psychologists, nurses, speech therapists, nutritionists, and so on. The diagnostic and therapeutic processes function best from the center of a medical model. Community Mental Health Centers may be such loci, but they are far in the future and our County and State Mental Health Boards must make realistic provisions for this now.

Many model and imaginative programs are going on today, giving medical and social care in depth, such as at the Sinai Hospital in Baltimore and Queensbridge in New York. These provide services without the cohesive and hope-sustaining emotional gratifications in primarily oriented psychiatric care. Even these do keep some of the elderly out of dead-end hospitals and nursing homes. Communities must make provisions for home care, day care, leisure time facilities, legal and financial counselling and protection, health and accident prevention, education, and total environmental considerations of the real needs of the aging. Efforts must be made to reorient social attitudes toward the aged, with more emphasis on optimism and realistic expectation. Research has long been lagging and is still meager. Finally, it is important that we, as therapists, take more time in individualizing the care of the elderly, not only to give them a sense of worth and belonging, but to treat them better that way.

The indiscriminate or desperate use of phenothiazines or antidepressants can precipitate a cerebral accident or a toxic delirium. The therapist may lose himself in individual or group psychotherapies, only to be too late to prevent a physical or even a reality-based crisis. This is not to disparage the use of these measures — I would not know what to do with acute confusional episodes, paranoid reactions and depressive reactions without drugs — but to point up their proper place in general management.

Bibliography

1. Cowdry, E. V.: *Problems of Aging,* 3rd ed., Williams & Wilkins, Baltimore, 1952.

2. Working with Older People, *The Practitioner and the Elderly,* Vol. 1, U.S. Public Health Service, Washington, 1967

3. *Problems of the Aging Psychiatric Patient,* Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Number 14 (Jan. 1961.)

4. Redlich, F., and Freedman, A.: *The Theory and Practice of Psychiatry,* Basic Books, Inc., New York, 1966

6. Busse, E. W.: Psychoneurotic Reaction and Defense Mechanism in the Aged, *Psychopathology of Aging,* Paul Hoch, M.D. and Joseph Zubin, Ph.D. Editors. Grune and Stratton, New York, 1961. Pp. 274-284.

7. Epstein, L. J. and Simon, A.: Alternatives to Hospitalization for the Geriatric Mentally Ill, *American Journal of Psychiatry.* 1:24 (pp. 955-961) 1968.

197 Passaic Avenue

Something other than the "masterly inactivity," once recommended for stroke by Sir William Osler, is now available.

Diagnosis And Treatment Of Cerebrovascular Disease*

Lawrence C. McHenry, Jr., M.D./ Philadelphia

In contrast to the tremendous advances of the treatment of heart disease and cancer since World War II, little progress has been made in the care of stroke. Anticoagulants and surgical treatment of extra-cranial vascular disease are now limited to well-defined instances. A more hopeful outlook, however, in the campaign against stroke has recently been brought about by the application of better diagnostic and research technics.

Anatomic and Physiological Background

The brain receives its blood supply from the two internal carotid and two vertebral arteries. These unite at the base of the brain to form the circle of Willis. This evolved from a diffuse network, the "rete mirable," from other species. The circle of Willis allows collateral circulation to pass from one side of the brain to the other and to the posterior fossa *via* the posterior and anterior communicating arteries. In addition to this source of collateral blood supply there are subarachnoid arterial anastomoses between the major cerebral and cerebellar arteries. The occlusion of a major artery can be compensated by blood from these other routes. As shown by Adams and his associates,[1] blood may flow into an occluded middle cerebral artery *via* collaterals from the anterior and posterior cerebral arteries. This can often be seen on cerebral angiography. The degree of collateral circulation is one of the factors that determines the size and extent of cerebral infarct.

Carotid and Middle Cerebral Artery Syndromes

Carotid artery occlusion as a cause of stroke was recognized early in the century, but Miller Fisher[2] must be given credit for bringing it currently to the attenton of our profession. Clinically, the picture is usually that of middle cerebral artery disease with or without ipsilateral visual blurring or blindness. Diminished carotid pulsation or arterial bruits may be present in the involved artery. A century ago, Charcot pointed out that the area of supply of the middle cerebral artery is the most frequent site for cerebral infarction. The first portion of this artery supplies penetrating end-arteries, the lenticulostriate branches, the basal ganglia, and internal capsule. Cortical branches cross over the surface of the cerebral hemisphere and send short and long penetrating branches into the gray and white matter of the brain.

Branches of the middle cerebral artery supply the motor and sensory cortex, particularly the centers for the face, hand, arm, and hip. The center for deviation of the eyes to the opposite side is also in its territory. In right-handed individuals the speech areas in the inferior frontal gyrus (Broca's) and the superior temporal (Wernicke's) area are in the distribution of the left middle cerebral artery. Deep in the white matter of the hemisphere

* Part of the Postgraduate Course at the Middlesex General Hospital, New Brunswick. Paper read February 16, 1968. Dr. McHenry is the Director, Stroke Research Center, Philadelphia General Hospital, and Assistant Professor of Neurology, Jefferson Medical College.

are not only the corticospinal tract and thalamocortical connections, but also the optic radiation in the posterior part of the internal capsule. Occlusion of the middle cerebral artery or one of its branches can produce mild confusion and hemiparesis; if collateral circulation is inadequate and infarction is extensive, a complete hemiplegia, hemianesthesia, homonymous hemianopsia, and aphasia occur. Also, since the middle cerebral artery is a direct continuation of the internal carotid artery, emboli from the heart or common carotid artery may lodge at the first or second bifurcation of the middle cerebral artery.

The Anterior and Posterior Cerebral Arteries

Clinical syndromes of the anterior and posterior cerebral arteries are rather infrequent. Infarction in the distribution of the anterior cerebral artery will produce weakness or sensory deficit of the opposite leg, confusion or dementia. Posterior cerebral artery occlusion can produce a variety of symptoms depending whether or not the penetrating thalamic and brain stem branches are involved. An homonymous visual field deficit follows occlusion of the calcarine branches. Near its origin the posterior cerebral artery supplies vessels to the midbrain. Weber's syndrome, a third nerve paralysis and contralateral hemiplegia, can result from occlusion of these vessels.

The Vertebral-Basilar Artery System

Clinical involvement in the vertebral-basilar system occurs almost as often as carotid-middle cerebral artery symptomatology. Basilar artery insufficiency produces ischemia or infarction of the brain stem and a variety of neurological syndromes. We have a plethora of neurologic eponyms from brain stem disease, named after late 19th and early 20th century European clinicians.

Ischemic injury of the pons is characterized by involvement of either one or both corticospinal tracts with or without damage to sensory tracts. In brain stem disease at any level abnormal eye signs usually develop from involvement of the third or sixth nerve nuclei or from the medial longitudinal fasciculus. Cerebellar findings with nystagmus and vertigo also frequently occur. In addition to these manifestations, involvement of the medulla, results in lower cranial nerve signs. In general in brain stem disease, the particular cranial nerves involved assist in localizing the level of the lesion. One of the classic lower brain stem syndromes is that of Wallenberg† due to occlusion of a vertebral or posterior inferior cerebellar artery .

In addition to the typical neurologic syndromes resulting from the occlusion of a particular vessel, general symptoms may occur in stroke. If the middle cerebral artery is involved, pain is referred to the side of the head. Posterior cerebral or basilar artery disease may produce occipital headache or neck pain. Convulsions also accompany cerebrovascular disease more often than expected. About 20 per cent of stroke cases will have seizures which usually can be successfully treated with phenobarbital and diphenyl hydantoin.

Dementia occurs quite often particularly with diffuse involvement of small vessels as in hypertensive or diabetic angiopathy. Disease of the small penetrating arterioles which supply the white matter, basal ganglia, and brain stem causes small infarcts or lacunes. Clinically, dementia, gait disturbances, and other signs may be present, Usually, however, in dementia or behavioral changes associated with cerebrovascular disease there is (when carefully sought for), a history of one or more "small strokes." All dementia is not due to vascular disease, the main cause more often being primary nerve cell disease.

Etiology of Stroke

Strokes, in general may be due to eight causes: (1) transient cerebrovascular insufficiency without infarction or transient

† Vertigo and nystagmus; loss of pain and temperature sensation on the ipsilateral face and on the opposite side of the body; dysphagia, dysarthria and Horner's syndrome occur along with ipsilateral cerebellar ataxia.

ischemic attacks; (2) cerebral infarction from a cerebral thrombosis or embolism; (3) intracerebral hemorrhage; (4) ruptured cerebral aneurysms or vascular malformations; (5) hypertensive encephalopathy; (6) inflammatory disease of arteries, such as lupus erythematosis; (7) dural sinus or cerebral venous thrombosis; or (8) cerebrovascular lesions following trauma extradural or subdural hematomas, and cerebral contusion.

The first four are by far the most common causes of stroke. The relative frequency, however, may vary with the population under consideration. Transient ischemic attacks and cerebral thromboses probably account for 70 to 80 per cent of the stroke patients. With the adequate prevention of rheumatic fever and subacute bacterial endocarditis, cerebral embolism has been seen less often, except occasionally a complication of cardiac surgery.

Clinically, the evolution of ischemic disease of the brain generally follows one of three patterns. The neurologic deficit usually comes on suddenly, but may occur in a stepwise or stuttering fashion. It may be preceded by transitory neurologic signs or symptoms days or weeks before the final episode. When the neurologic defect is stable, it is often called a "completed stroke." Neurologic deficits may be progressive — "progressing stroke"—or may be reversible — "reversible ischemic neurologic defect."

One of the most common cerebrovascular manifestations is often seen by the general physician. This is the transient ischemic attack or TIA. Re-emphasized recently as a specific entity** transient ischemic attacks are believed due to a temporary diminution in cerebral blood flow. In general, atherosclerotic lesions of the extracranial and intracranial vessels are multiple, with varying degrees of narrowing. It seems unlikely that any single lesion alone is the cause of a major ischemic syndrome; of primary importance is stability of the cerebral circulation and pathophysiologic changes that occur in stroke patients. Cerebral blood flow measurements in individuals with strokes have invariably shown about a 25 to 30 per cent diminution in overall cerebral blood flow. The specific neurologic syndrome produced depends on the vessel involved, as well as the availability of collateral circulation to the compromised area.

When transient neurologic symptoms occur, they are related to atherosclerosis of one or many vessels, and are closely tied to changes in cardiovascular hemodynamics. In patients with cerebrovascular disease, transient falls in blood pressure occur normally at night. Orthostatic hypotension or syncope from any cause, may precipitate a transient ischemic attack. Similarly, a fall in cardiac output from myocardial disease or a change in heart rhythm may lead to cerebral ischemic. Cerebral anoxia can follow gastrointestinal hemorrhage, hypoglycemia, acute dehydration, or chronic pulmonary disease with polycythemia.

Transient ischemic attacks are important to identify. In many instances they are forerunners of a progressive or completed stroke. They must not be disregarded merely because they are transient. This is the type of stroke in which there is room for active prophylactic treatment: anticoagulants as a means of preventing the more serious stroke or by carotid surgery in cases with specific lesions related to specific symptoms.

Clinical characteristics of transient ischemia can generally be separated into two groups: (1) Due to symptoms of disease in the carotid-middle cerebral artery system; or (2) Due to vertebral-basilar disease. In the first category weakness, clumsiness, or numbness of one side of the body, speech disturbances, and visual disturbances are prominent symptoms. In vertebral-basilar insufficiency transient diplopia, visual scotoma, vertigo, ataxia, "drop attacks," dysphagia, dysarthria, facial numbness, and alternating hemiplegia or hemianesthesia or quadraplegia are important manifestations.

** Sir William Gowers in his *Manual* (1888) described transient ischemic attacks. William Heberden in the 18th Century recognized that premonitory symptoms may occur before apoplexy.

Intracerebral hemorrhage associated with hypertension usually accounts for from 10 to 20 per cent of stroke patients. In an institution like the Philadelphia General Hospital, however, the incidence of intracerebral hemorrhage is as high as 40 per cent. Negroes (and they constitute a high proportion in our hospital) have a high incidence of hypertension at a relatively young age. Extracranial vascular disease, however, occurs *less* frequently in the Negro than in the white race.

Another cause of "stroke," that must be considered in large city hospitals, is trauma. Patients are often admitted to the hospital in coma or stuporous with a hemiparesis. Many are elderly or alcoholic and no history can be obtained. In this situation it is mandatory to rule out a surgically treatable subdural or extradural hematoma, before the patient is considered to be "merely another stroke."

Diagnostic Procedures in Patients with Strokes

In addition to a meticulous history, general physical examination and neurologic study, certain laboratory procedures are informative in the diagnosis and management of patients admitted with a "stroke." Lumbar puncture may reveal intracranial bleeding by the presence of xanthochromic or bloody spinal fluid. Also, a central nervous system infection with an "apoplectic onset" can be confirmed by leukocytosis in the spinal fluid. Syphilis(causing dementia or meningovascular lesions) can be confirmed by the spinal fluid serology. The colloidal gold curve and spinal fluid protein will assist in the diagnosis of intracranial lesions. A lumbar puncture (to rule out bleeding) must always be done before instituting anticoagulant therapy for transient ischemic attacks.

Skull x-rays are needed to search for fracture, detect a shift in the pineal gland, and for calcifications in blood vessels, aneurysms, or certain neoplasms. In patients with dementia, erosion of the sella trucica, suggesting increased intracranial pressure, may indicate a chronic subdural hematoma.

Cerebral angiography is considered by many to be the definitive diagnostic procedure in cerebrovascular disease. Lesions producing stenosis or occlusion of the extracranial or intracranial vessels can thus be visualized and correlated with the clinical findings. Mass lesions (tumors, aneurysms, or hematomas) or atrophy can usually be differentiated from primary occlusive vascular disease. Although cerebral angiography *via* carotid or brachial artery puncture has few complications, caution is necessary, especially in older patients with cardiovascular or other severe medical diseases. Angiography is probably *not* indicated in every stroke patient unless the diagnosis is uncertain, or unless it will have a measurable influence in determining the type of treatment. It is probably undesirable to do angiography when the patient shows definite signs of improvement after the onset of the stroke. On the other hand, all patients admitted to special centers for cerebrovascular research should have four vessel angiography in conjunction with other studies of cerebral circulation and cardiovascular function. Some other useful diagnostic procedures are ophthalmodynamometry, echoencephalography, electroencephalography, and brain scans. Individually, each test itself is limited in value and is rarely diagnostic of cerebrovascular disease. A careful clinical history and a meticulous examination is far more valuable. Electroencephalography and brain scanning with radioisotopes have been found useful in the assessment of stroke patients, but should never be considered other than helpful diagnostic tools. For example, four or five days after cerebral infarction the brain scan may reveal changes which could lead to a mistaken diagnosis of a cerebral tumor.

Elements in Treatment

Generally speaking, the treatment of the stroke patient is expectant and supportive. During the acute stage when the patient is incapacitated by a neurologic defect, he should be hospitalized. The basic aspects of medical management include the maintenance of adequate respiration, fluid balance, and nutrition, along with the prevention of

pneumonia and bed sores. Physical therapy in the form of passive exercises is begun on the first day of the illness and continued throughout stabilization or recovery.

Anticoagulants are indicated in individuals with transient ischemic attacks either in the carotid or vertebral-basilar artery system. Therapy can be initiated with parenteral heparin and oral Dicumarol.® It is usually continued for at least six months. In patients with completed strokes and fixed neurologic deficits, anticoagulants are not indicated. When a stroke patient has a progressing neurologic deficit while under the physician's observation, some doctors give anticoagulants.

In spite of the aggressive approach taken by some vascular surgeons, the general applicability of *extracranial vascular surgery* is in some dispute. At present a nationwide study by twenty-four medical centers is evaluating this form of treatment. In a similar vein, the surgical evaluation of intracerebral hemorrhage has been effective as one form of treatment, but this is beneficial only under specific clinical circumstances.

Drugs to improve cerebral circulation have not been of benefit in patients with completed or progressing strokes. Papaverine increases cerebral blood flow, but its effect on the natural history of the stroke has not been demonstrated. Similarly the use of intermittent carbon dioxide inhalation has been criticized. Since there is an increased carbon dioxide tension and maximal vasodilation in ischemic brain tissue, increasing the carbon dioxide tension in normal areas could shunt blood from an ischemic area of brain.

The use of steroids, low molecular weight Dextran,® hypothermia, and hyperbaric oxygen have not proved of repeated benefit in stroke patients. Steroids have effectively been used in treating brain edema, but generally not with the edema associated with cerebral infarction. Hypothermia reduces brain swelling and cerebral metabolism, but results in stroke patients have not been dependable. Hyperbaric oxygen has improved the neurologic status of some patients while in the chamber, but when they leave the chamber, symptoms usually return.

New Approaches in Diagnosis

Some new methods are now available in the diagnosis of cerebrovascular disease. In conjunction with cerebral angiography, regional measurements of cerebral blood flow have been carried out at the Stroke Research Center, Philadelphia General Hospital. A radioactive inert gas, Xenon-133, dissolved in saline is injected into the internal carotid artery. The clearance of the isotope from the brain is monitored by eight probes. From the clearance curves, blood flow in eight different regions of the brain can be determined. These flow values are then compared to changes seen on the angiogram. Using this method, the doctor can evaluate regional changes in cerebral circulation and their relation to stroke. With such methods as this a new approach can be taken to the diagnosis and treatment of cerebrovascular disease.

References

1. Adams, R. D. and Vander Eecken, H. M.: *Ann. Rev. Med.*, 4:213 (1953); also, Vander Eecken, H. M. and Adams, R. D.: *J. Neuropath. and Exp. Neurol.*, 12:132 (1953).

2. Fisher, M.: *Arch. Neurol. Psych.*, 72:187 (1954); also, Fisher, M.: *Arch. Neurol. Psych.*, 65:346 (1951).

Philadelphia General Hospital

Faced with a mysterious eruption, the physician would do well to think of a contact dermatatis. Industrial chemicals are common, though not the only offenders.

Relationship Of Occupational Contactants To Drug Eruptions*

A. A. Fisher, M.D./Woodside, New York

Exposure in industry by contact can sensitize individuals to certain chemicals which are either drugs or immuno-chemically related to systemically administered drugs. External exposure to the drug usually produces a typical eczematous contact dermatitis in the sensitized individual. The subsequent systemic administration of the drug can produce a distinctive systemic eczematous "contact-type" dermatitis medicamentosa.[1] The "contact-type" dermatitis produced from the systemic administration of the drug resembles the "initial" contact dermatitis except it is usually more widespread with the most marked reaction in those areas which had originaly been affected with the eczematous reaction from the occupational exposure. The table lists examples of certain industrial chemicals which may sensitize a patient by external contact and the corresponding immuno-related drugs which may produce an eczematous contact-type dermatitis medicamentosa upon systemic administration.

Industrial Contactants and Related Drugs

Industrial Contactants	Immuno-Related Drugs
Ethylenediamine HCL	Aminophyllin
Hydrazine Hydrobromide	Isoniazid, Apresoline, Nardil
Organic and Inorganic Mercurials	Mercurial Diuretics
Metallic Mercury	Calomel
	Protiodide of Mercury
Formaldehyde	Urotropin, Mandelamine
	Urised

Ethylenediamine

Ethylenediamine is used widely for synthesizing dyes, fungicides, synthetic waxes, insecticides, resins, and asphalt wetting agents. Its dibasic nature is utilized for neutralizing acidity of oils, preparing casein and shellac solutions, stabilizing rubber latex, inhibiting corrosion, or controlling alkalinity.[2]

Medical sources of ethylenediamine are: (1) aminophylline, which contains theophylline and ethylenediamine; and (2) a mixture containing triamcinoline acetone, neomycin, gramicidin and nystatin (Mycolog Cream®) in which ethylenediamine is used as a stabilizer. Aminophylline is capable of producing a contact-type dermatitis upon systemic administration to individuals previously sensitized to the topical application of ethylenediamine.[3]

Hydrazine Hydrobromide

This compound has the capacity to sensitize many of the people who are exposed to it. Hydrazine is widely used in pharmaceuticals, and in clinical and industrial processes. Hydrazine is the parent chemical from which are derived: Isoniazid (Inh, Niconyl, Nydrazind,® Rimifon,® Tyrjid®) Apresoline,® Hydrochloride, and Nardil® (phenelzine dihydrogen sulphate), an anti-depressant drug. The systemic administration of these drugs in individuals sensitized to hydrazine hydrochloride[4] may produce eczematous "contact-type" dermatitis medicamentosa.[5]

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*Read before the Section on Dermatology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 21, 1968.

The Mercurials

Sensitization to mercurials may be engendered by topically applied inorganic mercury such as ammoniated or bichloride of mercury, or by organic mercurials (i.e. Mercuro-chrome® or Merthiolate®). Once the patient has been sensitized to mercury by topical exposure the injection of a mercurial diuretic may produce an eczematous contact-type dermatitis medicamentosa. This same phenomenon has been observed in a patient who had been sensitized by ammoniated mercury and who subsequently ingested calomel[6] (mercurous chloride.)

The red portions of certain tatoos consist of mercury in the form of red cinnabar. Such red areas may flare when a mercurial diuretic is injected or other mercurial preparations are used.

A recent interesting report[7] concerns an individual who while at work received a laceration of a tattoo. Following this, he developed a localized, then a generalized eczematous eruption, apparently due to mercury. It is thought that the laceration was responsible for precipitating this generalized sensitization to mercury.

Formaldehyde

Patients sensitized by external exposure to formaldehyde may acquire eczematous contact-type dermatitis medicamentosa from the ingestion of Urotropin® (hexamethylenetetramine methanamine) which liberates formaldehyde in an acid medium.[8]

Bibliography

1. Fisher, A. A.: *Annals of Allergy,* 24:406 (April 1966)

2. Fisher, A. A.: *Contact Dermatitis.* Philadelphia, 1967, Lea & Febiger. Page 233

3. Provost, T.; and Jillson, O.: *Archives of Dermatology,* 96:233 (February 1967)

4. Wheeler, C.; Penna, R.; and Cawley, E.: *Archives of Dermatology,* 94:237 (August 1965)

5. Hovding, G.: *Acta Dermovenereologica* (Stockholm). 47:293 (March 1967)

6. Epstein, Simon: *Annals of Allergy,* 16:268 (April 1958)

7. Biro, L. and Klein, W.: *Archives of Dermatology,* 96:175 (January 1965)

8. Sulzberger, M. B.: *Dermatological Allergy.* Springfield, Illinois, 1940, C. C. Thomas and Company. Page 380

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Here is an interesting way of handling pulmonary emboli following vena cava ligation.

Venography In Recurrent Pulmonary Emboli Following Vena Cava Ligation

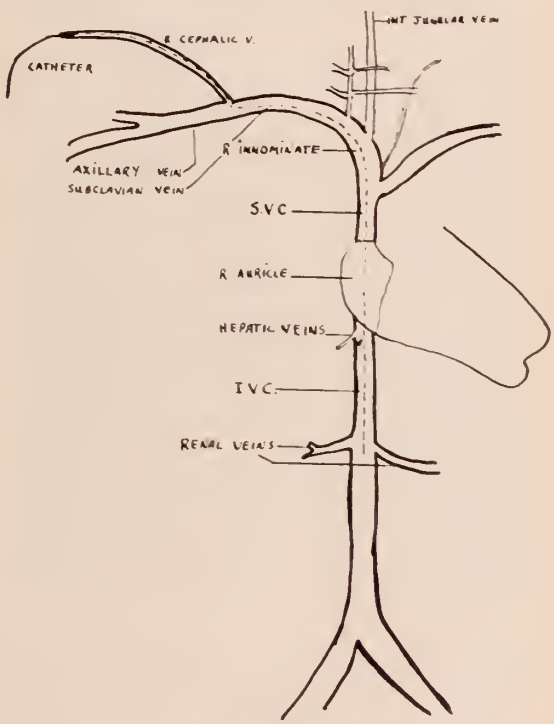
Robert P. Steinfeld, M.D. and L. Vincent Strully, M.D./Paterson

Pulmonary emboli are always serious problems but when the patient experiences recurrent pulmonary emboli following ligation of the inferior vena cava, the problem becomes even more acute. Clinicians often overlook the possibility that thrombi may form in an iatrogenically produced cul-de-sac between the site of ligation and the renal veins. We are proposing a venographic catheter technic for the diagnosis of new thrombus formation superior to this ligature around the inferior vena cava.

A 36 year old woman entered the hospital for evaluation of recurrent hemoptysis of several years' duration. Since age 27 this patient has had multiple hospital admissions for acute thrombophlebitis of both lower extremities. Seven years ago, she had been hospitalized for acute thrombophlebitis associated with hemoptysis and chest pain. A diagnosis of pulmonary embolus was made and she was anticoagulated with a good response. This was in 1960

In 1962, because of recurrent hemoptysis and chest pain the inferior vena cava was doubly ligated 2 centimeters below the renal veins. The common iliac veins were also ligated because of technical difficulties. Between 1962 and June, 1964 she was readmitted nine times for recurrent hemoptysis and chest pain. She responded well to anticoagulant therapy which was discontinued at the time of each discharge because she was considered to be too "unreliable" to follow medication orders.

In June, 1964 recurrent deep thrombophlebitis and chest pain were now associated with an infiltrate in the left lower lobe. Pulmonary arteriography, bronchography and bronchoscopy were all negative. The infiltrate cleared with antibiotic therapy. Femoral phlebograms revealed occlusion of the iliac veins and non-visualization of the distal inferior vena cava. On this admission it was decided to investigate the inferior vena cava to determine whether a thrombus was located above the ligature and distal to the renal veins. We devised the following method to evaluate this segment of the inferior vena cava.



(Figure 1)
Schematic drawing showing route of Teflon Catheter once it enters the cephalic.

A right cephalic vein cut-down was performed just proximal to the insertion of the deltoid and pectoralis muscle. Under flouorscopic control and using the image amplifier, we threaded a radio-opaque Number 7 Teflon catheter, 40 centimeters long, into the cephalic vein, axillary vein, subclavian vein, right innominate vein, superior vena cava, right auricle and inferior vena cava, past the hepatic veins and down to the level of renal veins.

After flushing the catheter with heparinized saline, 20 cubic centimeters of Conray 400 were hand injected

through the catheter to visualize the inferior vena cava, renal veins, and that segment of the inferior vena cava just distal to the renal veins. With the catheter in satisfactory position 40 cubic centimeters were introduced with an Amplatz® Injector and eight serial films were taken with a Sanchez Perez Changer at ¾ second intervals. With this injection, the patient experienced the same sense of warmth and discomfort found with any arteriographic study. This was transient, lasting but 5 seconds.

With the injection of the dye we noted rapid filling of the inferior vena cava as well as the right renal vein, (Fig. 2). No irregularity or filling defect was noted in that cone shaped opacification distal to the renal veins which represented the iatrogenically created cul-de-sac.



(Figure 2)
Conray 400 filling the right renal vein and cul-de-sac. Note cone shape opacification of segment of inferior vena cava extending distal to renal veins to the point of ligation of inferior vena cava.

As rapidly as the right renal vein filled, we noted the equally rapid emptying of dye from this vein up the inferior vena cava, (Fig. 3). The cul-de-sac continued to fill well. One and one-half seconds later (Fig. 4) both ostia of the renal veins were visualized well and only then was dye starting to empty from this segment of the inferior vena cava. Two observations were obvious through this study. (1) No filling defect was present in the cul-de-sac negating the possibility of new thrombus formation at this site and (2) Stagnation of blood (and dye) takes place in this cul-de-sac which might lead to new thrombus formation at any time

Once this study was completed, the catheter was removed and the proximal segment of the cephalic vein



(Figure 3)
Right renal vein is now emptying its dye back up the inferior vena cava while dye still remains in the cul-de-sac.

was ligated. A pressure dressing was applied and the patient was returned to her room with the routine post-angiographic orders. No untoward effects from this procedure occurred.

The problem of recurrent emboli following venous ligation — either femoral or caval — is an age-old one. Recurrent emboli following superficial femoral vein ligation may be[1] as high as 70 per cent. We are, however, impressed with the paucity of reported cases of recurrent pulmonary emboli following[2,3,4] inferior vena cava ligation.

Schauble[5] reports two cases of recurrent embolus but his patients had evidence of deep phlebitis in the upper extremities. Coon[6] reports 18 cases of inferior vena cava ligation with two deaths in the immediate postoperative period from emboli arising at and above the site of ligation. Brickman[10] records a case of inferior vena cava thrombosis just proximal to a Teflon® clip which had been applied just above the confluence of the common iliac veins. This ultimately resulted in right renal



(Figure 4)
Both ostia of the renal veins are noted. Dye is just starting to empty out of the cul-de-sac.

vein thrombosis and acute renal failure. Davis[8] is now in the process of reporting one documented case of the successful surgical removal of a thrombus serving as the source of emboli which had formed proximal to the ligature. Crane[7] has one case from a reported 104 vena cava ligations. Nevertheless, if and when recurrent pulmonary emboli do occur, the most likely source is from a thrombus located just proximal to the ligature and distal to the renal veins. Certainly, thrombus may develop in those segments of veins where venous stasis occurs. These sites in the femoral venous system are cul-de-sacs between valve pockets.[9] When the inferior vena cava is ligated the surgeon is, in essence, creating a cul-de-sac. Here venous pooling takes place which predisposes to thrombus formation and resultant potentially lethal emboli.

Although this study failed to demonstrate a thrombus in this patient at this time, it did enable us to investigate, with ease, a possible source of emboli. This study provided us with the information necessary to eliminate the need for re-exploration of this segment of the inferior vena cava. In addition, it demonstrated delayed emptying of the cul-de-sac, a cul-de-sac that is present in the greatest number of patients having ligation of the vena cava.

The relative importance of eliminating this "sac" is apparent. This may be achieved by a high ligation of the inferior vena cava immediately distal to the renal veins. The inferior vena cava should then be transsected to insure against recanalization.

Summary and Conclusions

1. Recurrent pulmonary emboli following ligation of the inferior vena cava are rare. When they do occur, however, the source of new emboli may be the cul-de-sac between the point of ligation and the renal veins.

2. A new venographic catheter technic for evaluation of this segment of the inferior vena cava proximal to the point of ligation is presented.

3. Stagnation of venous blood flow takes place in the iatrogenically created cul-de-sac which may lead to future thrombus formation.

4. Ligation of the inferior vena cava just distal to the renal veins would eliminate this cul-de-sac as a possible source of new thrombus formation and future emboli.

Bibliography

1. Anlyan, W. G., Campbell, F. H., Shingleton, W. W., and Gardner, C. E.: *Arch. Surg.*, 64:200 (February, 1952)

2. Dale, W. A.: *Surgery*, 43:24 (January, 1958)

3. Kirtley, J. A., Jr., Riddell, D. H., and Hamilton, E. C.: *Annals of Surgery*, 141:653 (May 1955)

4. Ochsner, A.: *Postgrad. Med.*, 27:193 (February, 1960)

5. Schauble, J. R., Stickel, D. L., and Anlyan, W. G.: *Arch. Surg.*, 84:17 (January, 1962)

6. Coon, W. W.; *Surg. Clin. N. Amer.*, 41:1343 (October, 1961)

7. Crane, C.: *New Eng. J. Med.*, 270:819 (April 16, 1964)

8. Davis, W. C.: Personal communication to authors

9. Allen, E. M., Barker, N. W., and Hines, E. A., Jr.: *Peripheral Vascular Disease*, 3rd ed. Philadelphia, 1962, Saunders.

10. Brickman, R. D., Risher, R. D., and Haller, J. A.: *J.A.M.A.*, 196:911 (June 6, 1966)

646 Broadway

Adolescent problems are usually rooted in family relationships. The family doctor is in an especially advantageous position to understand and to help.

Behavior Problems In Adolescents*

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The normal adolescent is in an "action-oriented" phase of life with a predilection for the expression of feelings and thoughts through behavior; behavior which is often impulsive, primitively aggressive, or sexual. There is a quality of unpredictability and changeability to the adolescent which baffles, angers, and dismays even the most patient of parents. The adolescent struggles for independence, proclaiming self-sufficiency and objecting to the protective restrictions of his parents. Yet, he often displays such incredibly poor judgment that his actions speak almost directly of his need for guidance. The apparent repudiation of the family's mores and values creates concerns regarding the adolescent's social and sexual behavior. Especially with the teen-age daughter, the intense infatuations with the opposite sex arouse the most distressing of parental anxieties. Although the adolescent rejects the ties to the family, the values of his peer group become most important. He must dress, act, and talk like the others, defending the most ludicrous styles by the protest "*we* like it;" the "we" being, of course, neither children nor adults but the fellow members of that unique group.

This relatively tumultuous phase of life has its roots in the biologically based drive toward maturation. Burgeoning sexual drives and social expectations combine to demand that the adolescent relinquish the security he has enjoyed as a child and find a new identity as an adult. He finds himself propelled by drives he does not understand into a different life role which is both promising and frightening. He is exposed to situations beyond his previous experience and knowledge and is required to resolve conflicts never before encountered. He is tempted to retreat to the role of the child and seek parental help and guidance, but this is now an anathema. He must struggle on, loudly proclaiming his self-sufficiency to conceal his uncertainty and fear. Because the still immature adolescent has not yet succeeded in mastering and integrating the suddenly increased instinctual drives, he experiences strong urges for the immediate behavioral expression of sexual and aggressive impulses. He cannot delay the press of the drives, and must experiment with a variety of modes and objects until finally a harmonious integration is once again achieved.

During this time of psychological turmoil, disturbed behavior is relatively common. Even in the "normal adolescent," all those kinds of symptomatic behavior (which in later life would be considered to be evidence of a neurosis or even a sexual perversion) may be observed in modified or attenuated form. These include the characteristic need to defy authority, the tendency for sadistic behavior, emotional outbursts, petty thievery, vandalism, and extreme narcissism, as well as the appearance of perverse sexuality including exhibitionism, voyeurism, and homosexual activity. The very frequency of disturbed behavior in this age group raises the question: just what *is* illness in the adolescent?

* Read by invitation May 3, 1967, at the Annual Meeting of the American Academy of General Practice held in Atlantic City, New Jersey. Dr. Wesselius is the Director of the Adolescent Treatment Program at the C. F. Menninger Memorial Hospital in Topeka, Kansas.

Maladaptive behavior occurs frequently in adolescence and thus creates a kind of "statistical norm." This does not mean that such behavior is without pathological significance. It cannot be dismissed as "merely typical teen-age acting up." Instead, this means that during this time of psychological stress, various kinds of serious behavioral symptomatology may occur without necessarily having the implication of future pathological personality development. During early adolescence all of these phenomena are "transitory"; and only if they persist to adulthood do we consider that they are truly crystallized character patterns which would lead to a diagnosis of personality disorder. Blos[1], for example, states:

"Any prognosis during adolescence must be made with skepticism and uncertainty. The eventual outcome may not be known until late or post-adolescence since the ego's synthetic capacity becomes apparent with clarity only during these phases. As we all know, it is just this fact that the adolescent is still in a period of growth and change that the potentials during this developmental phase cannot be overlooked."

Thus, in attempting to diagnose an adolescent, we are trying to evaluate a highly elastic personality structure. Under the pressure of the newly aroused instinctual drives, a variety of malformations may appear and then disappear, like bulges in the weaker areas of a balloon when the pressure inside is increased. They do not represent a fixed personality deformity or defect (as in the adult character disorder) and so a specific diagnosis cannot be made. An isolated episode of mutual masturbation in a young adolescent does not make a diagnosis of homosexuality. The theft of a comic book does not spell out an antisocial personality.

Behavioral symptoms, in themselves, do not point to a psychiatric diagnosis in the traditional sense. What shall we label a previously superior student who drops out of high school? The youngster who is found smoking marijuana? The teen-age girl who has become sexually promiscuous? The boy involved in senseless vandalism or meaningless thefts? What advice can be given the worried parents? They usually have presented their adolescent's behavior as inexplicable and as apparently having defeated attempts at reasoning or discipline. The examination of the adolescent may contribute little or no additional information to clarify the problem. He may merely appear to be a "normal" teen-ager whose behavior is "worse" or more deviant than most others.

This diagnostic dilemma may be clarified by shifting the focus from the behavioral symptomatology itself and directing attention to factors in the patient's milieu which may be contributing to the disturbance. Remember that the adolescent patient is experiencing his symptoms at a time of developmental growth and while still within the confines of the family from which he is emerging and ambivalently seeking independence. The behavioral problem may be recognized as symptomatic of certain types of relationships between the child and the parents. Although the behavioral symptoms in a number of cases may be superficially similar, nevertheless, they may represent widely divergent degrees and types of pathology.

The parent-child interactions which play a role in the development of behavioral symptoms may be placed in four major categories. In the first and simplest type, the appearance of behavioral pathology may be related to *inadequate parental support* available to the child.

When a youngster reaches puberty, he requires more parental attention than he did as a younger child. Through his latency years, from 6 to 12 or so, he was a relatively well-behaved and agreeable member of the family, but around the time of puberty he begins to acquire a different turn of mind. He now has independent ideas which may veer away from those of the family. He cultivates friends of his own and develops a life apart. Previously respectful of his parents' judgment and admonitions, he now can see they are fallible. When they suggest an appropriate time to be home in the evening, he may upbraid them for their old-fashioned ways, scornfully denouncing their attempt to "treat him as a child." To insist on obedience arouses storms of protest and angry recriminations, replete

with "everybody else can stay out late. Why did I have to have parents like you?"

Occasionally, parents, distressed and troubled by what appears to be a deteriorating relationship with a youngster with whom they once enjoyed warmth and closeness, may prematurely abdicate their authority in the pursuit of peace. Since to resist the child's demands produces tension and discomfort, they accept his pleas at face value. If this "understanding" response becomes the pattern of their relationship with the child, they have only succeeded in "misunderstanding" him. In this typical adolescent demand for greater personal freedom accompanied by a denunciation of the parent's wish to "treat him as a child," is hidden the adolescent's own wish to return to the protected security of childhood. Disturbed by his own desire to be looked after, he must consciously repudiate his wish and deal with it as though it were something others wish to impose on him.

This projective mechanism is often startlingly obvious in dealing with more troubled youngsters in a hospital setting. Frequently, if a request for freedom is granted prematurely, the adolescent reacts quickly and violently with behavior which expresses the anger and disappointment he experiences by the "rejection" he so vociferously demanded. The style of retaliation appears to be determined by what would "hurt" the parents most; in a girl this is often sexual behavior and in a boy, "failure" or aggressive destructiveness. By being left to his own devices, he is subject to even greater stimulation which leads to increasing needs for behavioral discharge. As a result of this cumulative effect, the youngster may exhibit increasingly primitive behavioral symptoms unless assistance is provided by some parental restraint and guidance.

It is often difficult for parents to see the wish behind the rebellion, but they sometimes can be reassured if they can recognize that this is a characteristic pattern of adolescence. Their task is to maintain a stable hub for the child, permitting the gradual acquisition of adult responsibility, based on observed evidence of the adolescent's adaptive accomplishments.

A fifteen-year-old girl was referred for hospital treatment because the family "didn't know what to do with her." Over the course of the preceding year she had found companions within a delinquent group, was truant, promiscuous, and was expelled from school. The parents had been too preoccupied with their own troubles to have the energy to deal with the child's adolescent needs. The mother, especially, was unable to tolerate her daughter's anger, and to purchase the child's verbal expressions of affection, had consistently compromised regarding the limits she placed on her child.

The first several weeks in the hospital were a prolonged battle about the whole gamut of her symptoms including obscene language, garish makeup, and sexually aggressive behavior. When her misbehavior was recognized as evidence of her social ineptness and dealt with by protective restriction and instruction, she reacted with anger and scorn. When, for example, she was informed that she could not have any cigarettes as her physician thought it wasn't good for her health, she was incredulous. She had smoked since she was twelve years old. Who was he to tell her she should stop? Everybody her age smoked. She could understand that the shrink was a hick from Kansas but no smoking was too much. Despite her diatribes, however, she could be noticed to be slowly modifying her previous behavioral style into something more subdued and acceptable. After some months had passed and she had settled down considerably, she reflectively reviewed some of her past. She specifically recalled that she had begun to smoke even though her mother had evidenced disapproval. When asked why her mother didn't make her stop, she replied she would just tell her mother where she could go. When the physician wondered why her mother hadn't given her, as old as she was, a paddling for such an attitude, her unexpected but revealing response was "that's a ridiculous question. You know, she never really loved me!" This youngster was saying: if the parent really loves the child, they will insist on what they believe is best, not what produces agreement.

In a second type of problem, the same behavioral symptoms may be present, despite what seems to be heroic efforts at parental control and discipline. In these instances the parents will emphasize the attempts to enforce some measure of control over their child's behavior, but relate that, despite their efforts, the adolescent's misbehavior has continued or even worsened. Frequently, in these instances, a closer examination of the adolescent-parent interaction reveals that although restrictive and even punitive measures have, indeed, been utilized, they have formed a certain *oscillating pattern.*

A child reaches sexual maturity and acquires a more independent and rebellious turn of mind. Parents may then react with an *exaggerated* prohibiting and punitive attitude. Seeing the adolescent struggle with a welter of aggressive and sexual impulses may arouse the parents' anxiety regarding their own un-

resolved adolescent conflicts over sexual expression and independence. Their child's press for instinctual expression threatens their own repressive control and their reaction is an anxiety-driven, overly harsh, and restrictive response. Following the subsidence of this acute reaction, the parent, in symptomatic fashion, then identifies with the forbidden impulses and becomes overly permissive. The adolescent who is endeavoring to find some stable guidelines around which to organize his own growth toward adulthood experiences his parents' vacillation for what it is—not a considered decision which is best for him, but rather as a reaction to his own conflicts. This creates additional anxiety and guilt in the adolescent and as the tension heightens in both parent and child, the swings become greater. Ultimately, incidents of extremely harsh discipline may alternate with a permissive attitude, hidden behind an aura of despair; such as "I can't do anything with you — go ahead, do as you please, I give up!" In these instances parents may be able to respond to support and a recommendation that the disciplinary lines be drawn consistent with the parents' best judgment and in consultation with each other, rather than in response to the feeling of the moment regarding their provocative child. Often, if the tension in such families can be relaxed, then both the parents' and adolescent's sense of balance and perspective may be retrieved and the maladaptive pattern arrested early in its development.

In a third type of problem, the same rebellious or delinquent behavior can be seen to have more serious implications. In these instances, it can be noted that the parents are not merely reacting adversely to their child's adolescent turmoil but rather are closely involved with the child in the delinquent behavior per se. Here, the parent has a certain kind of *neurotic investment in the child's behavior;* promiscuity, thievery, truancy, and so on. This is the kind of problem described by Aichhorn[2] and others, and as originally pointed out by Szurek[3], who stated, "Almost literally, and no instances in which adequate psychiatric therapeutic study of *both* parent and child has been possible, has it been difficult to obtain sufficient evidence to reconstruct the chief dynamics of the situation. The more important parent, usually the mother (although the father is always in some way involved), has been seen unconsciously to encourage the amoral or antisocial behavior of the child. The neurotic needs of the parent, whether excessively dominating, dependent, or erotic in character, are vicariously gratified by the behavior of the child or in relation to the child." An example is the mother who, by her initially unfounded accusations and overzealous inquiries, reveals her anticipation of the daughter's promiscuity, which then becomes an almost exclusive preoccupation because of her own problems and frustrations in this area. In another example, a young man had been hospitalized because of constant lying and cheating among other more serious symptoms. Although his lying had been the focus of violent angry clashes between father and son, nevertheless, during the course of hospitalization the father, while visiting (and while knowing that the patient was being held to a strict budget) slipped his son five dollars and said "It's just between us. You don't have to tell the doctor about this." Here we are not dealing with an "acute reactive" situation, but with a more seriously disturbed family situation. The message conveyed is "it's all right to lie and cheat, but just not with me." These youngsters, if they remain in the home setting untreated, will eventually demonstrate the distorted superego formation or "superego lacunae" decribed by Johnson.[4]

In other instances, the family's participation in the behavioral pathology may be in the nature of a neurotic entanglement wherein the parent is reluctant to permit the emancipation of the child and the child's behavioral problems reflect an attempted solution. These types of situations may be highly masked and the following case illustration may convey some of the subtleties of such an interaction within a specific family.

Miss B. was in her late teens when originally referred for treatment; an attractive and intelligent girl, one would have thought she would have a happy life ahead of her. Instead, over the previous few years she had been behaving in an irresponsible way. She was

fast acquiring a reputation for being promiscuous, had had affairs with married men, and been in frequent angry battles with her parents. She was the younger of two children. The brother was married, held a good job, and seemed to be making a very adequate adjustment. Miss B.'s parents were well-thought of in their community as a responsible, sober, and industrious couple. Mr. B. was employed in an executive capacity, and Mrs. B. was considered a good wife and mother. The daughter had certainly not been a neglected child. The family was considered an especially close-knit one. During her early years, our patient had seemed to be, in every way, a healthy, well-adjusted child. Why she had such current difficulties, particularly in her relationships with men, was a puzzle to her friends and family. Her problems were considered, by some, as additional evidence of the waywardness and the lack of morals of the younger generation.

This, then, was the general over-all view of the family, but let me tell you the picture of the family relationships which emerged in the course of Miss B.'s treatment.

The relationship between Mr. and Mrs. B, although cordial, had never been completely satisfying for either. Mrs. B. was a reserved, undemonstrative person. She had never provided Mr. B. with all of the attention, affection, and admiration he desired to bolster his self-esteem and sense of masculinity. There were important areas of compatibility, however, and despite the limitations of the marriage, it was a reasonably satisfying relationship for each. The patient, born a few years after the marriage, was welcomed by both parents. As a little girl, she developed a fondness for her father, as do all little girls. However, Mr. B., unaccustomed to this kind of attention, took a little extra satisfaction in the fact that at least one female member of the family not only thought a good deal of him, but wanted to spend time with him. His warm response to her bids for attention began to create a bond between them; and as the little girl grew older, there developed an especially close relationship. Whatever deficiencies had existed in the marriage were now filled by the daughter. With the father's need for companionship satisfied, the home was happier. The daughter obviously enjoyed her father's company, and it was equally obvious that she was his favorite. Family friends kidded the two of them about being such "pals." Mrs. B. silently resented the special closeness between her husband and her daughter, and this set up a bit of a wall between them.

As the little girl grew into her teens, father and daughter would occasionally have long, serious conversations about life and what each was looking for. Mr. B. took an interest in his daughter's boy friends, and frequently asked her about this or that fellow, wondering whether she was getting serious. As she did more dating, he seemed to become a little sad; and in one of their talks about life and marriage he told her about the unhappiness he had experienced in his own marriage with her mother. Gradually, the daughter became secretive about her social life, and began to draw away from both parents. They became concerned when they heard rumors that she was dating unsuitable men, and were eventually shocked when a friend informed them of their daughter's recent actions. A confrontation of their daughter by the now-united parents only resulted in her becoming angry, and defiant, justifying her behavior as being her own business. It was at this point that her worried parents sought help.

This patient's subsequent treatment revealed that even as a little girl she had sensed that she had filled a special role in her family. The relationship with her father was different than that of a normal close father-daughter relationship, so necessary for growth and development, as she also filled a crucial role in her parents' marriage. The father had made it evident that he found his marriage unsatisfactory and that it was she who held things together by supplying what he didn't receive from his wife. She was, as a child, pleased and gratified by this relationship, but also experienced a great deal of guilt regarding taking her mother's place. She had acquired a distorted view of marital relationships, and was entangled in something she didn't really comprehend. These life-long experiences in her own family had made it difficult for her to make a normal transition to adulthood. Instead, she continued her childhood pattern. Her parents were shocked when their daughter did something that really she had been experiencing all of her life — that is, "to be the other woman" in a marriage.

This family also had basically healthy elements in it, however, and was able to respond to help. The father soon recognized how his confiding in his daughter had constituted a burden for her. The daughter was relieved to have the opportunity to clarify her own thinking by talking with someone who could be objective about her confused feelings. She was eventually able to make a better adjustment and this, too, was accompanied by a shift in the relationship between her parents, who were able to give some serious thought to their own marriage.

In this example, the psychological problem underlying the girl's behavior is much more than adolescent turmoil and these situations require more definitive treatment to obtain a favorable prognosis. This particular pattern of family relationships has been noted by Beckett[5] who states, "Broadly speaking, in adolescents who are seen by a psychiatrist, the most frequent family situation is one where a close, or dependent, or even seductive, attitude exists between the parent of the opposite sex and the adolescent patient, and a rejecting distant, cold attitude between the adolescent and the same sexed parent."

In a fourth type of clinical problem the same behavioral symptoms may be seen to be related to more serious developmental deficiencies associated with earlier, more profound emotional conflicts.For example, the symptom of promiscuity may, in a relatively healthy patient, be related to a high level conflict associated with genital sexuality. In another patient the same symptom of promiscuity may be seen as derived from more primitive conflicts: oral conflicts. An example of this latter would be a young adolescent girl whose promiscuous behavior can be observed to have no relationship to any genuine heterosexual

interest, but rather as being utilized to purchase some kind of an attachment to another person in order to deal with a profound sense of isolation. What such a patient really seeks to create *via* what only appears to be heterosexual behavior, is the recapitulation of the symbiotic relationship with the mother, from whom she has never adequately been able to separate herself. What may appear to be delinquent behavior of the type above reviewed, is, in actuality, the chaotic efforts of an extremely inadequate ego structure endeavoring to make a move toward increased independence from the family.

In the same kind of way, truancy may not be a rebellion against authority but rather a retreat from a life situation which poses social and intellectual demands which the patient is unable to meet. In these cases, attempts to deal exclusively with the impulsive behavior are, in a sense, directed at a secondary symptom. The examination of these patients will probably reveal affective disturbances and thought disorders as well as a long-standing history of an inadequate and disturbed adjustment which antedates puberty.

Occasionally, there is the child who, because of his agreeable and compliant manner, causes no concern, and whose behavior may even be a special source of gratification for his parents. In some instances, this may represent a smoothly progressing adolescent process. However, the physician should be alert to the possibility that the parents, in their relationship with the child, have exerted an excessively repressive or inhibiting influence which has prevented him from making any real move toward emancipation. In these instances, the parents, usually by means of a variety of guilt-inducing mechanisms, secure compliant behavior by inhibiting the normal maturational process and at the expense of tremendous inner tension in the child who remains tied to them in an infantile way. In these instances, the physician's role may be that of counseling the family to encourage a more independent attitude in their child. To such parents healthy independence may seem like rebellion at first and the physician's continued assistance will be required in order that the child not be crippled in his progression toward maturity.

Summary

If the individual adolescent's pathology is examined, not as a separate entity but rather as a dynamic extension of the parent-child relationships, this can provide information useful in diagnosis and treatment. This diagnostic approach is, of course, common to all medicine. Although the parents' only complaint may be their child's cough, nevertheless, the physician must obtain a history of other systems and do a further examination if he is to determine whether the cough is merely a symptom of a local inflammation or a symptom of a more serious illness. So presenting symptoms of a behavioral disturbance may be pathognomonic of a wide range of psychological problems. In the latter instance, however, diagnosis requires the examination of factors external to the patient: the family itself. Here the family physician is in a uniquely advantageous position. Frequently, his knowledge of the members of the family enables him to be aware of those interpersonal factors which may not be apparent on the surface. In addition, he has already previously won the confidence of those concerned and thus can exert a significant influence, either directly in personal guidance, or by encouraging the seeking of specialized help.

Although the problems of adolescents are complex and demanding of time and energy, they offer the physician the distinctive gratification of participation in a constructive beginning to another adult life.

Bibliography

1. Blos, Peter: *On Adolescence*, New York, 1963, Free Press of Glencoe. p. 177.

2. Aichhorn, August: *Wayward Youth*, New York, 1935, Viking Press.

3. Szurek, Stanislaus A.: *Psychiatry*, 5:1 (January 1942)

4. Johnson, Adelaide: in *Searchlights on Delinquency*, K. F. Eissler, ed., International Universities Press, 1949, New York.

5. Beckett, Peter: *Adolescents out of Step*, Detroit, 1965, Wayne State University Press. p. 27.

Menninger Memorial Hospital

Almost every body cavity has yielded to the surgeon's knife. Here is an account of a previously exempt area.

Early Synovectomy In Juvenile Rheumatoid Arthritis*

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and
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With a fuller understanding of the pathologic processes of rheumatoid arthritis, the physician has been able to formulate a more comprehensive approach to therapy. While rheumatoid arthritis is a systemic disease, it has its initial joint manifestations in the synovium. Hollander, *et al.*†, have submitted evidence that rheumatoid arthritis is an immunodyscrasia. They have postulated that the rheumatoid factor, (gamma M), reacts in the joint with an altered gamma globulin, (gamma G), in a complex antigen antibody reaction. Both types of immunoglobulin that form this complex are elaborated by the lymphocytes and plasma cells of the synovial tissue. Intra-articular reaction and compliment fixation of this material apparently evoke a foreign body inflammatory reaction. and the particulate complex is phagocytosed by the leukocytes. Ultimate deterioration of these leukocytes release lysosomal enzymes which damage joint tissue and perhaps break down more gamma G and initiate a vicious cycle. Thus, the synovial tissue is both the source of the antibody rheumatoid factor and the gamma G antigen. The joint space is site of continuing inflammatory reaction. It would, therefore, seem reasonable that (if suppressive therapy could not control the elaboration of the reacting immunoglobulins) surgical extirpation of the diseased synovium might then be indicated so that the amount of antigen and antibody in the joint could be reduced. If this is correct, it would be advisable to remove the diseased synovium before the lysosomal enzymes had the opportunity to destroy the joint cartilage.

Rheumatoid arthritis is a capricious disease that waxes and wanes over a span of many years. It is, therefore, difficult to judge the efficacy of any form of therapy unless a sufficient number of patients are evaluated over a protracted period of time. Our experience in early synovectomy of the adult rheumatoid joint has indicated that the procedure can give lasting results in most patients and has encouraged us to assess its value in a pilot project in the juvenile rheumatoid joint.

The juvenile joint is different from the adult joint in that both of the bones that make up the articulation, have epiphyseal plates which regulate growth and form. Damage to the epiphysis can produce a growth disturbance, and interruption of epiphyseal blood supply can lead to growth arrest or deformity. It is this serious potential of epiphyseal disturbance that limits our indications for surgical intervention to the most involved joints.

*Read before the Section on Rheumatism, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

†Hollander, J. L., *et al.*: Four studies on the pathogenesis of rheumatoid joint inflammation. *Annals of Internal Medicine*, 62:126 (February 1965).

Our program for the juvenile rheumatoid patient has been one of intensive and total care. Following the diagnosis, a treatment program is formulated to include medication and physical therapy. This is adjusted according to the patient's response to therapy. This treatment program is directed at the suppression of synovitis and the prevention of contractures. A joint that continues to manifest synovial activity while under medical care, is a candidate for synovectomy. We have arbitrarily selected one year as the minimum of treatment before performing synovectomy, but possibly this can be shortened as experience is gained.

Most of these children have activity in many joints and after a year of intensive medical care they may continue to have chronic smoldering activity in one or several joints. It is these smoldering joints that progress to inevitable destruction. It is this smoldering joint that we have subjected to synovectomy.

Thirty-five patients have had 45 synovectomies over the past three years. Ten have had 15 synovectomies with minimum follow-up of one year and form the basis for this report.

Synovitis of the proximal interphalangeal joint presents as a fusiform distention with restricted motion and early recurvatum deformity. This synovium can readily be removed through a dorsal approach. Usually all four fingers are involved and can be treated as one procedure.

Synovitis of the metacarpo-phalangeal joints usually presents as swelling in the palm adjacent to the metacarpal heads. The flexor tendon sheaths are commonly involved. Synovectomy is done through a transverse palmar incision.

Synovitis of the wrist usually involves the dorsal extensor tendons, but may also involve the intercarpal joints. Synovectomy can readily be performed about the extensor tendons and the radio-carpal joint. It is not practical to enter the intercarpal joints. Occasionally the volar carpal canal will be the site of synovitis and this area is also suitable for synovectomy.

The hip is a common area of involvement and the usual expression of activity is pain, muscle spasm, stiffness and contracture. Synovectomy has been performed through an anterior approach without dislocation of the femoral head. About 75 percent of the synovium can be removed without jeopardizing the blood supply to the femoral head.

The knee is a common site of synovitis. Synovial thickening, effusion, and contracture are quite evident. An anterior synovectomy is carried out with complete removal of the suprapatellar pouch and the infrapatellar fat pad.

Ankle synovitis and proliferation are manifested by bulging of the synovium from the anterior or posterior aspect of the joint. Usually two incisions are required adequately to remove the synovium.

These joints are immobilized following surgery for a minimum of time which in most instance is about four or five days. Thereafter, a careful physiotherapy program with regulated exercise is carried out. A near normal synovium is functioning by the third post-operative week and full activity is permitted as soon as the joint has full motion, good musculature, and no evidence of inflammation.

The results thus far for the initial fifteen synovectomies have been encouraging. There has been no clinical evidence of recurrence of synovitis in the surgically treated joints. There has been no clinical or radiographic evidence of epiphyseal derangement and this has been verified by roentgenographic evaluation every six months. There has been nothing to suggest that the surgery has had an untoward effect on the disease process.

Synovectomy has been performed on children from 6 to 17 years of age with an average age of 9.7 years. This is an interim report of an on-going project; end results cannot be

reported at this time. We can only state that the progress thus far has been encouraging for this pilot project. Additional studies are being developed to evaluate further the efficacy of synovectomy in the rheumatoid child.

3400 Spruce Street

The Non-Clotting Heart Valve

A non-clotting heart valve has been developed and tested successfully by a Temple University research team. This is the first valve that does not cause clotting and does not necessitate the use of the sometimes toxic anticoagulant drugs.

Dr. Julio C. Davila, a professor of surgery at Temple, and the valve's developer, has used the new device on thirteen critically ill patients. Seven survived. One has gone for a year and four months and another for almost a year without evidence of clotting. The deaths were caused by complications not related to clotting or the surgery.

Manufacturer of the new prosthesis, designed specifically for the mitral valve, is the Sierra Engineering Company of Sierra Madre, California. It was presented to the profession in October 1967 at the American Heart Association in San Francisco.

Through repeated use of many of the other valves, the Temple research team found that thrombosis occurred where material foreign to the body came in contact with growing scar tissue. The partly healed scar tissue formed thrombi and failed to heal completely.

Most of the valves were designed to prevent the attachment of clots to valve surfaces. But sometimes the clots would form and break free, floating into the blood stream to clog the circulatory system or break off as emboli.

Davila concentrated his research by first determining why clots should form between the valve and the imperfect scar tissue. He found the tissue's healing efforts were being frustrated because it could not encapsulate the foreign material. The research also indicated there is less chance of clotting when the blood is exposed to living tissue covered over by endothelium.

With this new knowledge of the cause of clotting, Davila then set about finding a material and designing a valve that would encourage endothelium-covered scar tissue to encapsulate it. Out of this came a new two-piece device. One part is made of fine, monafilament Dacron in a ring like cuff, that can be sutured to the tissue. The other part is a solid, smooth plastic occluder or valve which moves up and down with the beat of the heart to regulate blood flow. The felt cuff allows the formation of a well-healed tissue capsule. And because of the material's porosity, a good blood supply is ensured for the valve capsule.

Davila's work has been supported since 1960 by about a million dollars in grants from the John A. Hartford Foundation.

"The significance of this development lies in extending the resources of heart surgery to more patients than can be safely treated today," the Temple surgeon said. It also opens up a new source of research for those involved in developing other prostheses for spare part surgery, including a total artificial heart which experts predict will be a possibility within the next few years.

When the intern's service functions clash with his quest for education, what takes precedence? The educational function, says Dr. Zangara.

Internship In The Community Hospital

Anthony J. Zangara, M.D./Morristown*

Because of the excess of intern positions available in United States hospitals compared with the number of new doctors being graduated yearly, the question is asked whether *any* community hospital should continue to offer this type of medical education. If this question is answered affirmatively, then one needs to inquire as to *which* community hospitals should perform this function. The internship in such hospitals must be scrutinized in relation to the total program of medical education within the institution.

Medical education in a community hospital can be divided into three categories:

A. Training programs

1. Residencies in particular specialties.
2. Residencies in family or general practice.
3. Internship
4. Clinical clerkships (externships)
   a. For credit
   b. Elective

B. Continuing education for the medical staff.

C. Post-graduate medical courses for practicing physicians, (the staff *and* others)

1. Under the auspices of larger medical centers or medical schools (on-going programs)
2. Short courses (½ to 2 days) or symposia on selected topics.
3. Individual lectures and/or seminars.

Categories "B" and "C" overlap. Category "B" is intended primarily to include staff conferences, CPC's, audits, and like activities meant for staff organizations but available for teaching and learning if properly conducted. The work of the tissue committee is an outstanding example of the potential of this type of education.

Internship

Internship should be a continuation of the educational process of the young doctor. In many instances, however, it is an anomalous year repeating what most students have already had in a fourth year of medical school. The American Medical Association has revised its definition of the rotating internship and has made the 'rotations' largely elective with the hope that each student will choose the subjects he feels he needs and wants, either because of his future plans or his present knowledge and experience. Hopefully, he will be guided in his choices by a director of medical education or some other physician who can suggest the areas he should study. Even so, many of those concerned with medical education are worried that deficiencies are overlooked and doctors may begin practice without having done some of the things which previously everyone who had completed medical school and a rotating internship could be assumed to have performed at least once (e.g. suture a laceration, do a pelvic examination, perform a fundoscopic exam).

There is *no* argument about the basic philosophy that the internship must be an educational experience. If it is to be educational, the "students" (interns) must be considered students by *all* parts of the hospital. They are not really "employees." Their educational needs must be considered as primary with

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any attendant service aspects secondary.

The service aspects are important in training physicians. The experience they gain in dealing with other members of the hospital family (nurses, clerks, maintenance people, etc.) is an essential part of their training. So too are "routine" procedures done on patients. But none of these must be take permitted to take precedence over education. For example, it is important to know how to start an intravenous. However, repeated requests to do this type of procedure (which can be done by a trained nurse) detract physically, temporally, and emotionally from the educational experience of an intern. When this demand is coupled with angry words, when it arouses indignation on the parts of the various persons concerned, the resulting scene is the very antithesis of good education. It has become increasingly clear from observed trends, from the American Medical Association Council on Education publications, and from recent communications from the various specialty boards, as well as from other sources — governmental and private — that drastic and revolutionary changes in the delivery of medical care (and therefore in medical education) will be occurring.

Basic Needs

What is required in the community hospital to result in *education* of an intern? The following certainly should exist:

(1) An appropriate attitude and a feeling of commitment to the education of house officers by the doctors, the administration, and — as representatives of the community — the trustees.

(2) Dedication to this by those who agree to be the clinical teachers of house officers.

(3) Availability of clinical cases for the house officers to study and follow.

(4) Preferably (but not necessarily) a recognized, adequately staffed residency program in each of the major clinical specialties (medicine, surgery, pediatrics, and obstetrics).

(5) Good library facilities available (not necessarily *on* the premises).

(6) Special educational opportunities such as:

(a) Lecture by visiting professors.

(b) Attendance at *regional* (other hospitals) and national medical meetings.

(7) Fringe benefits are important. These include:

(a) Good salary.

(b) Good living conditions for family and for "on-call" rooms.

(c) Tokens of acceptance in the hospital — such as bonuses, social gatherings at the homes of attendings, formal "graduation exercises," special awards, Alumni Association activities, field trips, a doctors' table in the dining room.

(d) Payment of licensed house officers for extra work (e.g. in the Emergency Room).

(e) Special orientation for foreign physicians.

Is it worth it?

All of these "conditions" require a great deal of effort and money. Why should a hospital invest this much time, energy, and money, plus commitment of all resources of the hospital to develop an educational program? The primary mission of the hospital is patient care, not education. But patient care is better with the intellectual ferment of an educational program. Moreover, *every* hospital's primary mission is, or ought to be, patient care — even in the hospitals *owned* and run by medical schools. Good educational programs attract good interns and a good attending staff. The practicing doctors remain good and up-to-date because of the educational programs. This improves the educational program. In this way, a cycle results which hopefully spirals upward giving ever better medical care to the community. Like all good things, this requires effort, energy, time, and money. The community hospital must decide whether it wants to commit itself to education and once committed consider seriously and with open-minds what needs to be done to help establish and nurture a program of excellence. Striving for less is not worthwhile.

Bibliography

1. Eisele, C. W.: *The Medical Staff in the Modern Hospital.* McGraw-Hill, New York, 1967

2. "Essentials of an Approved Internship:" American Medical Association, Chicago, 1967

3. "Medical Education in the United States: Council on Medical Education. *J.A.M.A.* 202:726 (1967)

4. Millis, J. S.: Report of the Citizens Commission on Graduate Medical Education, American Medical Association, Chicago, 1966

5. Proceedings, 64th Annual Congress on Medical Education, Council on Education, AMA, Palmer House, Chicago, 1968.

6. Zangara, A. J.: "Medical Education at Morristown Memorial Hospital," A report submitted to the medical staff, February, 1968.

100 Madison Avenue

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 17, 1968

A regular meeting of the Board of Trustees was held on July 17, 1968 at the Executive Offices in Trenton. For your further information, detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Medical Society Executives' Meeting . . . Authorized the President, Chairman of the Board, and Executive Director to designate MSNJ representatives to attend a meeting co-sponsored by the American Association of Medical Society Executives and the American Medical Association to be held August 19 to August 21 in Chicago.

AMA Congress on Occupational Health . . . Authorized the attendance (with expenses paid) of the Chairman of MSNJ's Committee on Occupational Health, Workmen's Compensation, and Rehabilitation, Dr. Joseph A. Lepree, at the AMA Congress on Occupational Health, to be held September 30 and October 1 in New York City.

AMA Legal Conference . . . Authorized the attendance (with expenses paid) of the Society's Acting Legal Counsel, E. Powers Mincher, at the AMA Legal Conference to be held October 4 in Chicago.

Congress on Medical Ethics . . . Authorized the attendance (with expenses paid) of the Chairman of MSNJ's Judicial Council, Dr. Albert F. Moriconi, at the Congress on Medical Ethics sponsored by the AMA Judicial Council to be held October 5 and 6 in Chicago.

Elizabeth General Hospital Anniversary . . . Authorized Dr. Emanuel M. Satulsky to attend in behalf of MSNJ a dinner commemorating the 75th anniversary of the Clinical Society of The Elizabeth General Hospital and Dispensary on October 19 in Elizabeth.

Utilization Guidelines Under Medicare (Part B) . . . Directed that suggested guidelines drawn up by the Prudential Insurance Company (fiscal intermediary under Part B of Medicare) be referred to the Council on Medical Services, or a subcommittee thereof, for investigation and report to the Board.

Report of Acting Legal Council . . .

(1) *Constitutional Amendment* . . . Directed that a copy of Legal Counsel's opinion concerning the implementation of the new constitutional amendment affecting the composition of the Board be circularized to all county societies. (The statement indicated that it is not within the purview of the Board under the Bylaws to designate incumbents for the new Board positions created by the House of Delegates).

(2) *Tonometry and Optometrists* . . . Accepted the report of Acting Legal Counsel which concurs with the opinion of Deputy Attorney General Saros that licensed optometrists have the right to make tonometric examinations using anesthetic drops.

AMA Delegates . . . Received the report of the New Jersey Delegation to the 1968 AMA Annual Meeting.

Council on Legislation . . . Approved the following recommended positions on current state legislation:

(a) *Bills to be noted and filed:*

A-944—To authorize the Department of Health to promulgate rules and regulations governing the packaging and labeling and sanitation and other conditions relating to the manufacture, processing, distribution and sale of frozen desserts; to include special frozen dietary foods, mellorine frozen desserts in the meaning of the term frozen desserts.

AJR-11—To reconstitute and continue the Narcotic Drug Commission created in 1962 and reconstituted in 1964 and 1966.

(b) *Bills for action:*

S-97 —To require every applicant for a motor vehicle driver's license upon first applying — and every 6 years thereafter — to submit to, and pass, a hearing and eye examination as shall be prescribed by the Director of Motor Vehicles. *ACTION DEFERRED,* pending study and recommendation by the Society's Committee on Traffic Safety (referred by the Council 2/8/68).

S-736—To permit licensed physicians to place or assist in placement of a new-born child for adoption and to permit attorneys to execute legal documents in connection therewith. (Similar to S-799) *ACTION DEFERRED,* pending opinion from the New Jersey Obstetrical and Gynecological Society and the American Academy of Pediatrics.

S-761—To establish five regional evaluation centers for mentally retarded, physically handicapped, emotionally disturbed, socially maladjusted and multi-handicapped children. *NO ACTION*

S-776—To provide for the registration and licensing of electrologists by the Board of Medical Examiners. (Similar to A-821) *APPROVED*

S-799—To exempt physicians and attorneys from criminal penalties in connection with adoption placements. (Similar to S-736) *ACTION DEFERRED,* pending an opinion from the New Jersey Obstetrical and Gynecological Society and the American Academy of Pediatrics.

S-825—To authorize the school medical inspector to accept the report of physical examination of a pupil by his treating physician. (MSNJ-sponsored measure) *ACTIVE SUPPORT*

S-833—To appropriate $200,000 for establishing State Medical Examination laboratory facilities. (Similar to A-702) *APPROVED*

S-850—To establish a medical assistance program for the recipients of Old Age Assistance, Assistance for the Permanently and Totally Disabled, Assistance for the Blind and their spouses and recipients of Assistance for Dependent Children, for persons eligible for assistance except for durational residence requirements and for children between 18 and 21 eligible for assistance except for lack of school attendance or pursuit of formalized vocational or technical training. *APPROVED*

SJR-26—To create a commission to study and evaluate the effectiveness of existing laws, rules and regulations relating to the practice of all branches of the healing arts dealing with any part of the mind or body of human beings.

The Council unanimously agreed that when this resolution is passed the Society should request and participate in a public hearing.

A-553—To provide medical service corporation privileges and benefits to licensed pharmacists for services performed therefor. (Action deferred 5/9/68, pending further study and clarification by the New Jersey Pharamaceutical Association and the Hospital Service Plan of New Jersey.) *NO ACTION*

A-760—To provide a licensed practicing psychologist, psychiatrist, or psychiatric social worker within a community mental health center with reimbursement for service performed under any policy of accident and sickness insurance. *DISAPPROVED*

A-761—To provide that benefits under any policy of accident and sickness insurance shall not be denied any individual when services are performed by a licensed practicing psychologist, psychiatrist or psychiatric social worker. *DISAPPROVED*

A-762—To provide a licensed psychiatrist or psychiatric social worker within a community mental health center with reimbursement for services performed under any policy of group accident, group health and group accident insurance. *DISAPPROVED*

The Council considered A-760, A-761 and A-762 as companion bills and unanimously agreed upon a position of "disapproved" for all of them. Insofar as licensed psychiatrists and psychologists are concerned, these bills are unnecessary because these individuals are already entitled to reimbursement for eligible services to eligible subscribers which they render under the scope of their professional licenses. In reference to psychiatric social workers these bills are undesirable because such individuals are not licensed or in any other way authorized to serve as dispensers of health care services, and the bills do not include a definition to indicate the actual work a psychiatric social worker is permitted to perform.

A-788—To authorize the Commissioner of Health to establish and operate not more than six community health centers. *NO ACTION*

A-790—To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

A-806—To provide that no hospital emergency receiving room shall be open for treatment unless there is in attendance at least one person on the staff who speaks English and is capable of interpreting same in the language of the licensed medical practitioner in charge of such room. *APPROVED*

A-821—To provide for the registration and licensing of electrologists by the Board of Medical Examiners. (Similar to S-188 and S-776) *APPROVED*

A-845—To regulate and control the sale and distribution of drugs, medicines and poisons and the practice of pharmacy by prohibiting ownership by other than pharmacists. *NO ACTION*

A-856—To define "unnecessary radiation" in the Radiation Protection Act to mean the use of

electromagnetic radiation including microwave, infrared, visible, ultraviolet, x-ray and gamma-ray, and particle radiation including alphas, betas, high energy electrons; to provide for embargo of appliances believed to be hazardous and to provide penalties for violations. *APPROVED*

A-884—Increases Unemployment Compensation and Temporary Disability Benefits; also provides that unemployment and temporary disability benefits insurance are required only when the employer has four or more employees. *APPROVED*

A-916—To provide for the registration and regulation of orthopists.

The Council took no action on this bill because it became law on June 25, 1968 as Chapter No. 114. Introduced on June 17, it had passed both Houses by June 20, at which time *no printed* copies were yet *available*.

A-925—To authorize persons who successfully complete a course of training in a public or private hospital, or who have assisted physicians for not less than two years, to carry out limited ancillary technical procedures in assistance of physicians. *ACTIVE SUPPORT* (MSNJ sponsored measure)

A-932—To designate the State Department of Health as the sole agency to have the central, comprehensive responsibility for the development and administration of the State's policy with respect to hospital and related medical care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, except mental institutions and institutions for care of the mentally ill; to create a Health Care Administration Board. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES*, because in its present form too great a concentration of power is given to the Commissioner of Health in promulgating rules and regulations.

. . . Directed that preparation be made to set forth constructive suggestions and recommendations to modify A-932 and, when recommendations are in final form, that representatives of MSNJ, the New Jersey Hospital Association, and the Commissioner of Health meet with the Governor's Legal Counsel to present the Society's position.

Referral from the 1968 House of Delegates . . . Appointed Dr. John J. Bedrick and Dr. Louis K. Collins as the Society's official legislative educational representatives, and Dr. Meyer L. Abrams and Dr. Henry J. Mineur as alternate representatives, in accordance with a directive from the 1968 House of Delegates — substitute resolution for Resolution #2 (Essex County, page 371, July 1968 JOURNAL), Resolution #22 (Mercer County, page 384, July 1968 JOURNAL), Resolution #24 (Atlantic County, page 385, July 1968 JOURNAL), and Resolution #34 (Middlesex County, page 391, July 1968 JOURNAL)—to tighten up the legislative keyman process and use the services of selected MSNJ members or any other legislative assistants as official legislative lisaison agents of the Society.

. . . Directed that the President, Chairman of the Council on Legislation, and the Executive Director meet with qualified candidates for the position of legislative assistant and decide upon the best suitable terms.

Project Hope/Vietnam . . . Approved the recommendation of the Committee on Project Hope/Vietnam that a $1,000 fellowship be given to Robert W. Tilney, Jr., M.D. (Morris County) at the beginning of his tour of duty with the *S.S. Hope*, scheduled for October 13.

. . . Directed further that should Doctor Tilney's tour of duty be changed the foregoing action would be subject to modification.

Medical Service Administration . . . Approved the following nominations for membership on the Board of Governors of the Medical Service Administration:

Irving P. Borsher, M.D.
Joseph I. Echikson, M.D.
Lloyd M. Felmly
Elton W. Lance, M.D.
Jerome C. Rothgesser, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
Thomas J. White, M.D.

Air Pollution Conference . . . Approved a request from Roslyn Barbash, M.D. that she be designated as MSNJ's official representative to the AMA Air Pollution Medical Research Conference to be held July 22 to July 24 in Denver.

MSNJ Parliamentarian . . . Appointed Henry A. Davidson, M.D. as MSNJ's Parliamentarian for 1968-69.

Why Belong To The Medical Auxiliary?

Mrs. Kustrup, the President of the Woman's Auxiliary to The Medical Society of New Jersey, has suggested that all male physician readers of THE JOURNAL will be interested in this item which originally appeared in *The Shingle*. The Medical Society has always been interested in the further development of its Auxiliary, and it is suggested that you talk this over with your wife, if she is not already a member.

Why belong? The Medical Auxiliary *is you*. From the time you said "I do" to your doctor husband, you assumed with him a responsibility to the medical profession. Whatever your former training, medical or otherwise, you now have a foremost goal—to build a good life together while making a good living, thus having a complete partnership in life and profession.

You might start out working hard staying home, helping in the office and having babies. Join the medical auxiliary—you are already one of us. You will receive our New Jersey publication, *The Shingle*, which tells of our endeavors and accomplishments. You will receive our national magazine *MD's Wife* which is well illustrated and interesting reading. You will also receive communications and invitations from your County Auxiliary. Once in a while when that "housebound" feeling hits, attend a luncheon program or help with a community project, especially one in which your husband is interested. We will be content with the time you can give us and you will find a comfortable companionship with other doctors' wives who *want to know you*.

Most of us belong to and help support the auxiliary to the hospital where our husband works, in addition to our interest in community health. This is an important purpose of our Medical Auxiliary. The 1922 resolution creating the Woman's Auxiliary to the American Medical Association stated as its first objective: "To extend the aims of the medical profession through the wives of the doctors to the various women's organizations which look to the advancement in health and education." We can be proud of our many members affiliated with health organizations.

Mutual understanding among physicians and their families has played an important role in the development of the Auxiliary. Stated in the Constitution and Bylaws is the following objective: "To cultivate friendly relations and promote mutual understanding among physicians' families." Much can be accomplished on a basis of friendship and common interests.

Now we have WA-SAMA—the Woman's Auxiliary to the Student American Medical Association. Started in May 1957, there are now more than 60 chapters with more than 6,000 active members in this national fast-growing organization. WA-SAMA's goal is to make the "entrance of the medical wife to the active profession more easily accomplished and more effective." They feel that the wife is an "integral part of her husband's medical career," and that she "has the responsibility to be as competent in her role as the physician's wife as her physician must be in his." They will be most valuable future members of our medical auxiliary.

If you have been a member, dormant for a while, come back. Ours is not an organization from which we retire. We want every doctor's wife or a member of his family to represent him. The Auxiliary to the Medical Society—county, state, and national depends upon you.

Eva W. Kustrup
President
Woman's Auxiliary

What Is Your Best Longevity Record?

The ability of physicians to maintain life for long periods in the unconscious patient raises the question as to how long such skills should be deployed. We are eager to promote recovery whenever we can. To deprive no one of his chances on this score, it is relevant to

know the longest periods of coma which have been followed by useful survival.

The Massachusetts General Hospital is studying its own records and the world literature to determine pertinent features in all patients who, *despite coma for over five weeks,* have made a useful recovery, and would be grateful if any reader of this JOURNAL will draw attention to any case published under a title which is not indicative of survival after prolonged coma. They are also eager to receive accounts of such cases as yet unreported.

If you have had a patient (or know of a patient) who has survived in coma for more than five weeks, write to Dr. William H. Sweet, Massachusetts General Hospital, Boston, Massachusetts 02114.

The Appeal For Lower Fees

America's doctors overwhelmingly agree with the appeal of a past president of the American Medical Association that raises in fees should strictly keep pace with inflation. The former AMA president is Dr. James Z. Appel, a general practitioner, who said that for doctors "to make a fortune out of people's illnesses is not quite ethical." He asked his fellow physicians to "hold down the acceleration of our professional incomes" and to increase fees only "enough to keep pace with inflation." Dr. Appel also called on doctors to help cut down their patients' hospital bills.

Of the 1,200 physicians who answered a monthly national poll (called *Playback*) conducted by Marion Laboratories, a whopping 75 per cent agreed with Dr. Appel's appeal to hold fees down only to inflation increases (20 per cent disagreed).

In his appeal, Dr. Appel had cited his own fee for a routine office visit—$4. The Marion poll asked physicians, for comparison, "What is your standard fee for a routine office visit?" Results showed that Dr. Appel is nearly alone; most doctors charge more than $4.

Rehabilitative Services For Your Patient

Do you know that you can tap the resources of one of the most progressive rehabilitation services in the country? You *can*—through the New Jersey State Rehabilitation Commission. This agency is concerned with the vocational rehabilitation of mentally, physically, and emotionally handicapped residents of our state. There are, of course, some eligibility criteria that have to be met. And under some circumstances, you may be reimbursed by the Commission for rehabilitative services that you render. However, this requires prior authorization. The medical director of this program, Jarvis M. Smith, M.D., suggests you communicate with the Rehabilitation Commission, Labor and Industry Building, John Fitch Plaza, Trenton. For more specific information, call or write to the field office nearest you. Please write the phrase New Jersey Rehabilitation Commission before each address:

Schwehm Building
Atlantic Avenue
Atlantic City 08401
Phone — 609-345-5965

673 High Street
Burlington 08016
Phone — 609-387-0264

12 North Pearl Street
Bridgeton 08302
Phone — 609-451-9098

413 Broadway
Camden 08103
Phone — 609-966-2893

19 N. Harrison Street
East Orange 07017
Phone — 201-648-2883

520 Westfield Avenue
Elizabeth 07208
Phone — 201-351-5434

10 Banta Place
Hackensack 07601
Phone — 201-487-7890

108 High Street
Hackettstown 07840
Phone — 201-852-4110

895 Bergen Avenue
Jersey City 07306
Phone — 201-653-2350

5 Schuyler Place
Morristown 07960
Phone — 201-539-3660

80 Mulberry Street
Newark 07102
Phone — 201-648-3493

63 Morris Street
New Brunswick 08901
Phone — 201-545-8120

370 Broadway
Paterson 07501
Phone — 201-271-3050

750 Hamburg Turnpike
Pompton Lakes 07442
Phone — 201-835-1080

54 Broad Street
Red Bank 07701
Phone — 201-842-4700

1 East High Street
Somerville 08876
Phone — 201-526-0550

616 Washington Street
Toms River 08753
Phone — 201-244-2020

Labor and Industry Bldg.
John Fitch Plaza
Trenton 08625
Phone — 609-292-2940

79-81 Cooper Street
Woodbury 08096
Phone — 609-848-5300

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of July:

	July 1968	*July 1967*
Aseptic Meningitis	21	15
Primary Encephalitis	0	0
Post-Infectious Encephalitis	0	0
Hepatitis, Total	115	104
Infectious	86	86
Serum	29	18
Malaria	9	6
Servicemen	8	
Civilian	1	
Meningococcal Meningitis	16	8
Mumps	56	*
German Measles	11	*
Measles	58	11
Salmonella	73	58
Shigella	23	13

* Reporting only since October, 1967.

The Staphylococcal Nasal Carrier

The Communicable Disease Control Section is frequently questioned regarding the detection and treatment of carriers of *staphylococcus aureus*. The following is the policy of the Hospital Infections Unit of the N.C.D.C.

On routine culturing for *staphylococcus aureus* 3 types of nasal carriers are found in a hospital population – persistent carriers; intermittent carriers, accounting for about 65 per cent of the normal population; and persistent non-carriers who never or rarely harbor *staphylococcus aureus* in their anterior nares.

Most persistent carriers carry *staphylococcus aureus* in the anterior nares, though a few carry a staphylococcal strain in the axilla or perineum. Strains residing in carriers vary in their virulence and some carriers disseminate *staphylococcus* aureus into the environment. Persistent carriers who disseminate the organism seem to represent an especially important epidemiologic resevoir. Several nasal culture surveys of hospital personnel can detect persistent carriers, but they do not indicate which carriers disseminate their organism, nor do they indicate which strains are likely to infect others. Emphasis should be placed on effective surveillance systems which permit recognition of staphylococcal infections. If an increased number of staphylococcal infections is thus revealed, epidemiologic investigation, including nasal culture surveys, should be undertaken to discover sources of infection. An association should be sought between phage type or antibiogram of staphylococci isolated from lesions and those isolated from the anterior nares.

When a staphylococcal disease problem exists, and a carrier has been implicated, the carrier should be removed from patient contact and treated with topical intranasal antibiotics. Systemic antibiotics have proved ineffective in eradicating staphylococcal nasal carriage.

Measles Immunization Activities

In late June, a Board of Health in Monmouth County reported 43 cases of measles which had occurred in May in children between 6 and 13 who attended one school in the township. Twenty of these cases had been verified as measles by physicians. Since the school was closed for the summer, a measles susceptibility study was not done. Slightly more than a week later an immunization program was organized, and on July 10th 519 children were immunized against measles, 245 of whom were pre-schoolers. The policy of making measles immunization a prerequisite to school admission is being considered by the Board of Education.

Aseptic Meningitis

In late June, the Division of Preventable Diseases was notified of a possible outbreak of aseptic meningitis in a famly in Hunterdon County. The index case was a nine year old boy who developed headache and lethargy rapidly followed by persistent vomiting and nuchal rigidity. Spinal fluid examination showed 900 white cells, normal sugar content, and negative culture. During the following week, 10 other family members between age 3 and 34 developed similar complaints. The attack rate for the family group was 69 per cent. All of these individuals had headache, fever and lethargy, and over 90 per cent had vomiting. One of the cases had a

rash. Although these individuals felt ill enough to stay in bed, only the index case was hospitalized. Throat washings and stool and blood specimens were collected and an ECHO 9 virus isolated from 6 out of the 11 ill family members.

A similar outbreak of aseptic meningitis was investigated in Somerset County in July. Four cases, between 3 and 11 years of age, occurred within four miles of each other over a three week period. Three of the children lived in the same housing development and had had close contact with one another. All of the children had headache and fever and spinal fluids compatible with aspetic meningitis. One child had a rash. Several family members had similar, though milder, symptoms. Specimens for viral culture were submitted to the Division of Laboratories. One of the spinal fluids has thus far shown an ECHO 9 virus.

The etiology of viral encephalitis or meningitis cannot be determined on the basis of clinical symptoms alone. The Virology Laboratory of the New Jersey State Department of Health can provide such diagnostic services. Our Department is very anxious that specimens be submitted on all such cases for viral diagnostic tests so that appropriate public health measures can be taken. An acute blood, three stool, and spinal fluid specimens should be obtained as soon as the diagnosis is suspected and a convalescent blood specimen obtained two to three weeks later. These should be sent to the Virology Laboratory accompanied by a requisition form (Vir-1) available from all hospital laboratories.

The First FLEX In History

The first *Federation Licensing Examination* (FLEX) (which has been in the development stage for more than seven years) was administered in June 1968. Over 2500 applicants were examined. This is the first time a single examination for medical licensure was prepared and adminstered for licensure in more than one state.

The Federation of State Medical Boards of the United States was responsible for researching and developing the examination. The National Board provided the questions.

Previously, many physicians wishing to relocate and practice medicine in another state were compelled to be re-examind by that state. This has proved to be a constant source of annoyance among physicians in years past. It is expected that FLEX will not only reduce such problems, but at the same time achieve uniformity in licensing examinations, equivalent levels in the examinations, and improvement in the quality of examinations.

Eligibility for the examination is limited to those who have completed or nearly completed at least one year of internship or other graduate training approved by the state board. The requirement of one year internship (or graduate training) may be waived in 1968 only, in any state where circumstances require. It is acknowledged that the period of this waiver might need to be extended.

The 3-day test, which is administered by members of the state boards, will be repeated December 10, 11 and 12, 1968. For security reasons, it has been decided to conduct it on the same three days throughout the United States. Scores are reported directly to the participating states, which will have the option of interpreting them as they see fit.

ATTENTION

May we please remind our members that current professional liability insurance coverage under American Mutual will terminate on November 1, 1968. All transfers to our new carrier, Employers Insurance of Wausau, should be achieved without delay. Address applications for new coverage to The Joseph A. Britton Agency, 15 South Munn Avenue, East Orange, New Jersey 07018.

Mental Retardation—Our Problem

The primary role of the physician in the diagnosis, treatment, and programing for the mentally retarded can no longer be avoided by the medical profession. The Medical Society of New Jersey recognizes this and urges the participation of the physician in all phases of the program. The pediatrician, obstetrician, psychiatrist, and pediatric neurologist all have a special interest and competence in this field. It is, however, the family doctor, the G.P.—the primary physician—who has the initial responsibility of utilizing the medical competence necessary to bring to fruition diagnosis, treatment, and counseling and to facilitate planning for the mentally retarded.

The mandatory P K U screening law in New Jersey, may be a bad law, but is nevertheless the law and it is mandatory that the attending physician on all newborn infants insure screening after a minimum of forty-eight hours of protein stress in the nursery.

The current mental health code RS 28-30, (May 1965) has established guide lines for admission to an institution for the mentally retarded. Every physician ought to have a copy of this statute for his immediate use. The pertinent and salient points are summarized for quick reference when dealing with the mentally retarded:

Under Title 30, Mental Deficiency is defined as that state of mental retardation in which the reduction of social competence is so marked that persistent social dependency, requiring guardianship of the person, has been demonstrated or can be anticipated. Mental Retardation is a state of significant subnormal intellectual development, with reduction of social competence in a minor or adult person. This state of subnormal intellectual development must have existed prior to adolesence and be expected to be of life duration.

Applications for admission to a state institution must be made under one of these four classes:

Glass F—Application to the Commissioner by the parent, guardian, or person or agency having care and custody of the person of a minor, or by the guardian of the person of a mentally deficient adult.

Glass G—Application to the Commissioner by a mentally retarded person over 18 years of age, on his own behalf.

Glass H—Application to the Commissioner by a Juvenile Court having jurisdiction over an eligible, mentally retarded minor.

Glass I—Application to the Commissioner with an order of commitment to the custody of the Commissioner used by a court during or following criminal process involving the eligible mentally deficient person.

Application is made on special forms and accompanied by relevant information. You may get advice on procedure for admission to one of the institutions for the mentally retarded in New Jersey from Dr. Maurice Kott, Director of the Division of Mental Retardation, State Office Building, Trenton, or from Dr. Lloyd McCorkle, Commissioner of Institutions and Agencies, State Office Building, Trenton.

Here is a run-down of the State institutions for the retarded.

1. The State School at Vineland (Herbert Schultz, Superintendent) is for girls over the age of 5. Phone is 609-691-7700.

2. The Johnstone Training Center is at Bordentown. This co-educational institution is for the educable or trainable only. The Superintendent is Joseph Parnicky. The phone is 609-298-2500.

3. The State Colony at Woodbine is for boys over the age of 5. The phone is 609-891-206. The Superintendent is Harry Von Bulow.

4. The Training School at Woodbridge (phone is 201-636-3400) is co-educational with an age minimum of 5. David Rosen is the Superintendent.

5. The North Jersey Training School at Totowa is under the management of Dennis Buttimore, its Superintendent. Phone is 201-256-1700. Totowa is for females over the age of 5, but accepts infants of either sex in its nursery.

6. The State Colony at New Lisbon is for males over the age of 5. The Superintendent is Frank Russell. The phone is 609-894-2211.

Note: Each institution has criteria for admissions, and the request for admission is processed through Dr. Kott's office in Trenton.

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Committee on Mental Retardation

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John S. Madara, M.D. ..... Salem
Thomas H. McGlade, M.D. ..... Camden

Project Hope/Vietnam

Thomas C. DeCecio, M.D., *Chairman* ..... Cliffside Park
Nicholas A. Bertha, M.D. ..... Wharton
Harold L. Colburn, M.D. ..... Mount Holly

Retirement Plan For Physicians

Nicholas E. Marchione, M.D., *Chairman* ..... Vineland
Richard R. Chamberlain, M.D. ..... Maplewood
Albert F. Moriconi, M.D. ..... Trenton
Herbert W. Weisman, M.D. ..... Bayonne

Traffic Safety

Irwin S. Smith, M.D., *Chairman* ..... Willingboro
John J. Crosby, M.D. ..... Jersey City
Albert Ehrlich, M.D. ..... Fort Lee
Robert S. Garber, M.D. ..... Belle Mead
Gustav Ibranyi, M.D. ..... Newark
William J. Moore, M.D. ..... Trenton
William L. Sprout, M.D. ..... Salem
Frank B. Vanderbeek, M.D. ..... Paterson

PRESIDENTS, SECRETARIES, AND EXECUTIVE SECRETARIES OF COMPONENT MEDICAL SOCIETIES

Atlantic

Leonard S. Ellenbogen, M.D., *President* ..... Atlantic City
William G. Wosnack, Jr., M.D., *Secretary* ..... Atlantic City
Mrs. Jo Ann Raco, *Exec. Secretary* ..... Margate City

Bergen

Stewart F. Alexander, M.D., *President* ..... Park Ridge
Frank R. Begen, M.D., *Secretary* ..... Hackensack
Mr. Allen W. Fincke, *Exec. Secretary* ..... Hackensack

Burlington

William R. Muir, M.D., *President* ..... Mount Holly
Arthur C. Dietrick, M.D., *Secretary* ..... Medford
Mrs. Ruth E. Bunning, *Exec. Secretary* ..... Medford

Camden

William A. Halbeisen, M.D., *President* ..... Cherry Hill
Robert S. Gamon, Jr., M.D., *Secretary* ..... Cherry Hill
Mrs. Florence J. Yeager, *Exec. Secretary* ..... Merchantville

Cape May

Norris D. Bunn, M.D., *President* ..... Somers Point
Joseph M. Fitzgerald, M.D., *Secretary* ..... Cape May

Cumberland

Leonard G. Scott, M.D., *President* ..... Bridgeton
Frank J. T. Aitken, M.D., *Secretary* ..... Bridgeton

Essex

William Greifinger, M.D., *President* ..... Newark
Richard R. Chamberlain, M.D., *Secretary* ..... East Orange
Mr. Arthur R. Ellenberger, *Exec. Secretary* ..... East Orange

Gloucester

David R. Brewer, Jr., M.D., *President* ..... Woodbury
Don B. Weems, Jr., M.D., *Secretary* ..... Wenonah
Mrs. Doreen Ficara, *Exec. Secretary* ..... Woodbury

Hudson

William Yudkoff, M.D., *President* ..... Bayonne
Edmond A. Utkewicz, M.D., *Secretary* ..... Jersey City
Mrs. Julia Z. Wolf, *Exec. Secretary* ..... Jersey City

Hunterdon

Bernard L. Schapiro, M.D., *President* ..... Flemington
James R. Wiant, M.D., *Secretary* ..... Glen Gardner

Mercer

Karl T. Franzoni, M.D., *President* ..... Trenton
Peter J. Norton, M.D., *Secretary* ..... Trenton
Mrs. Annette B. Nicholas, *Exec. Secretary* ..... Trenton

Middlesex

Jack E. Shangold, M.D., *President* ..... Perth Amboy
Alan Young, M.D., *Secretary* ..... Woodbridge
Miss Carolyn M. Kidd, *Off. Secretary* ..... Edison

Monmouth

Harold Gabel, M.D., *President* ..... Oakhurst
Pascal L. Federici, M.D., *Secretary* ..... Long Branch
Mrs. Mary Gorman, *Exec. Secretary* ..... Avon

Morris

S. H. Malcolm Plum, M.D., *President* ..... Morristown
Hillel M. Ben-Asher, M.D., *Secretary* ..... Morristown
Mrs. Irma E. Crum, *Exec. Secretary* ..... Morristown

Ocean

George L. Triebenbacher, M.D., *President* ..... Beach Haven
Stanley Siegler, M.D., *Secretary* ..... Toms River
Mr. John Schaefer, *Exec. Secretary* ..... Jackson

Passaic

Samuel T. Bernson, M.D., *President* ..... Pompton Lakes
Elias D. Lawrence, M.D., *Secretary* ..... Paterson
Mrs. Katherine Cingale, *Exec. Secretary* ..... Paterson

Salem

Dorson S. Mills, M.D., *President* ..... Elmer
Charles G. Young, M.D., *Secretary* ..... Woodstown

Somerset

Alfred S. Conston, M.D., *President* — Somerville
Lawrence L. Livornese, M.D., *Secretary* — Somerville
Mrs. Betty Menapace, *Exec. Secretary* — Somerville

Sussex

Harold V. Coes, Jr., M.D., *President* — Sussex
Frank P. Marchese, M.D., *Secretary* — Sussex

Union

George L. Erdman, M.D., *President* — Summit
Howard H. Lehr, M.D., *Secretary* — Elizabeth
Miss Mary Louise Roger, *Exec. Secretary* — Elizabeth

Warren

Herman Smith, M.D., *President* — Phillipsburg
Ralph M. L. Buchanan, M.D., *Secretary* — Phillipsburg
Miss Jane Stamets, *Exec. Secretary* — Phillipsburg

1968-1969 SPECIAL COMMITTEES SPECIAL/LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
Joseph P. Donnelly, M.D., *Chairman* — Jersey City
Thomas C. DeCecio, M.D. — Cliffside Park
Nicholas E. Marchione, M.D. — Vineland
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
Chairman, Committee on Medical Education
Louis F. Albright, M.D. — Spring Lake

American Medical Association—Education Research Foundation

(Liaison requested by AMA — 10/7/51)

Chairman, Committee on Medical Student Loan Fund
Frank J. Hughes, M.D. — Gloucester

Audit Review Committee (1967-1968 Audit)

(Appointed annually by Board to review previous year's audit)

Nicholas A. Bertha, M.D., *Chairman* — Wharton
Louis F. Albright, M.D. — Spring Lake
Louis K. Collins, M.D. — Glassboro
Frank J. Hughes, M.D. — Gloucester
Nicholas E. Marchione, M.D. — Vineland
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* — Trenton
Thomas C. DeCecio, M.D., *Chairman, Finance and Budget Committee* — Cliffside Park

Bicentennial History

(Committee appointed to expedite distribution of history — 5/12/67)

Emanuel M. Satulsky, M.D., *Chairman* — Elizabeth
Richard I. Nevin, *Executive Director* — Trenton

Blood Bank Commission of New Jersey

(1) Formation of Commission authorized by 1953 House of Delegates
Authorized agent of MSNJ in approved Blood Bank Programs
(2) Appointment of two representatives requested by Commission — 4/5/54
Jerome G. Kaufman, M.D. — Maplewood
John J. Torppey, M.D. — Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)

Frank J. Hughes, M.D., *Chairman, Board of Trustees* — Gloucester
John F. Kustrup, M.D., *President* — Trenton
Richard I. Nevin, *Executive Director* — Trenton
Nicholas A. Bertha, M.D. — Wharton
Equal representation from:
Medical Service Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Control, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)

Frank J. Hughes, M.D. (June 1971) — Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing — 11/21/65)

Jesse McCall, M.D. — Newton

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety — 9/61)

Board of Trustees

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety — 9/17/61 . . . appointed by the Director of Motor Vehicles)

Jerome G. Kaufman, M.D., *Chairman* — Maplewood
Harry Kaplan, M.D. — Trenton
James G. Kehler, M.D. — Woodbury
Jesse McCall, M.D. — Newton

Chamber of Commerce Legislative Conferences

(Invited by Chamber — 1/15/61)

Richard I. Nevin, *Executive Director* — Trenton

Chronic Sick, State Advisory Council

(Commissioner of Health requested MSNJ submit names to Governor — 10/16/60 . . . apointed by Governor for 3-year term)

David Eckstein, M.D. (1971) — Trenton

Civil Defense Organization, Liaison With State

(Liaison established by MSNJ — 5/22/55)

Jack R. Karel, M.D., *Chairman, Committee on Emergency Medical Care* — Hillside

Crippled Children Commission, State

(Appointed by Governor for a 5-year term)

Frederick G. Dilger, M.D. (May 1971) — Hackensack

Diabetes Detection Drive

(Liaison representative for annual drive—co-sponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ — appointed at request of Commissioner of Health — 5/16/54)

John J. Torppey, M.D. — Newark

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60) — Quorum: 4 members

1st District —
Ralph M. L. Buchanan, M.D., *Chairman* — Phillipsburg
Robert F. Zimmerman, M.D. — Morristown
2nd District —
John J. Bedrick, M.D. — Bayonne
Robert A. Cosgrove, M.D. — Jersey City
3rd District —
John S. VanMater, M.D. — New Brunswick
John A. Kinczel, M.D. — Trenton
4th District —
John C. Clark, M.D. — Asbury Park
Robert S. Gamon, Jr., M.D. — Camden
5th District —
A. Guy Campo, M.D. — Westville
Nicholas E. Marchione, M.D. — Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education — 9/21/58)

William J. Farley, M.D., *Chairman, Committee on Child Health* — Nutley

Emotionally Disturbed Child, Advisory Council to Department of Education

(Three names requested for appointed of 1 by new Commissioner — APPOINTMENT HAS NOT YET BEEN MADE)

William L. Rumsey, Jr., M.D. — Elizabeth
William J. Farley, M.D. — Nutley
Albert Schmidt, M.D. — Sea Girt

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles— 7/29/66)

J. Berkeley Gordon, M.D. — Rumson

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))

John F. Kustrup, M.D., *President* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Emanuel M. Satulsky, M.D., *First President* — Elizabeth
E. Vernon Davis, M.D., *Second Vice-President* — Mount Holly
Frank J. Hughes, M.D., *Chairman, Board of Trustees* — Gloucester

Fluoridation, Joint Committee on

(Established at request of the State Department of Health)

Edwin H. Albano, M.D. — East Orange
John P. Coughlin, M.D. — Jersey City
Equal representation from:
State Department of Health
New Jersey State Dental Society

Foreign Interns, Committee to Study Licensure of

(Established by MSNJ — 12/18/66 —)to work with the Board of Medical Examiners)

Louis K. Collins, M.D., *Chairman* — Glassboro
A. Guy Campo, M.D. — Westville
Jesse McCall, M.D. — Newton

Headquarters, Investigation of Future

(Committee established by Board — 6/19/66)

Nicholas A. Bertha, M.D., *Chairman* — Wharton
Samuel J. Lloyd, M.D. — Trenton
Emanuel M. Satulsky, M.D. — Elizabeth

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service — 7/19/64)

Presidents of Component Societies

Health Facilities Planning Council

(MSNJ invited to nominate 3 members for the Board of Trustees — 2/16/64 . . . appointed by Council to serve for a 3-year term)

Louis F. Albright, M.D. (1970) — Spring Lake
John F. Kustrup, M.D. (1969) — Trenton
Jesse McCall, M.D. (1971) — Newton

Health Insurance Conference

(Committee established at request of Health Insurance Council — 3/24/57)

Marcus H. Greifinger, M.D., *Chairman* — Newark
Jerome G. Kaufman, M.D. — Maplewood
Fred A. Mettler, M.D. — Blairstown
John F. Kustrup, M.D., *President* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Emanuel M. Satulsky, M.D., *First Vice-President* — Elizabeth
E. Vernon Davis, M.D., *Second Vice-President* — Mount Holly
Richard I. Nevin, *Executive Director* — Trenton

Health, State Department of

(Liaison requested by Commissioner of Health—6/6/54)

John P. Coughlin, M.D., *Chairman, Council on Public Health* — Jersey City

Heart Disease, Cancer, and Stroke

University City Science Center, Philadelphia
(Established at invitation of University City Science Center — 12/65)

Louis K. Collins, M.D. — Glassboro

Historian-Archivist

(Created at the suggestion of the Executive Director — 1/13/57)

Morris H. Saffron, M.D. (Appointed May 1967) Passaic

Hospital Association, New Jersey

(Invitation extended to Executive Director to serve on the Board of Trustees)— 12/17/67)

Richard I. Nevin, *Executive Director* — Trenton

Hospital Advisory Council, State Department of Institutions and Agencies

(Appointed by the Board of Control for a 4-year term)

Luke A. Mulligan, M.D. (December 1969) — Leonia

Hospital Service Plan Board of Trustees

(Provided in HSP Bylaws)

John F. Kustrup, M.D., *President* — Trenton

House Maintenance, Staff Policies, and Personnel Relations

(Special committee created by Board of Trustees — 9/21/58)

John F. Kustrup, M.D., *President, Chairman* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Marcus H. Greifinger, M.D., *Secretary* — Newark

Samuel J. Lloyd, M.D., *Treasurer* — Trenton
Frank J. Hughes, M.D., *Chairman, Board of Trustees* — Gloucester
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* — Cliffside Park

Industrial Safety Board, New Jersey
(Appointed by the Governor for 1 year term — 10/16/66)
Joseph A. Lepree, M.D. (February 1969) ... Elizabeth

Institutions and Agencies, State Department of
(Liaison established 7/16/61)
Frank J. Hughes, M.D. — Gloucester

Intra-Hospital Infections, Joint Committee on
(Established at request of Commissioner of Health — 4/8/62)
Edwin H. Albano, M.D., *Chairman* — East Orange
Lawrence Gilbert, M.D. — Newark
Thomas K. Rathmell, M.D. — Trenton
Eugene H. Kain, M.D. — Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

JEMPAC, Conference Committee With
(Established at request of JEMPAC — 6/25/67)
Jesse McCall, M.D., *Chairman, Council on Legislation* — Newton
Louis K. Collins, M.D., *Chairman, Council on Medical Services* — Glassboro
E. Vernon Davis, M.D., *Second Vice-President* — Mount Holly

Judiciary and Bar, Conference Committee on Inter-Relations with the
(Established at invitation of Supreme Court—11/17/63)
John P. Coughlin, M.D. — Jersey City
E. Vernon Davis, M.D. — Mount Holly
Joseph P. Donnelly, M.D. — Jersey City
Joseph M. Gannon, M.D. — Plainfield
Marcus H. Greifinger, M.D. — Newark
Jerome G. Kaufman, M.D. — Maplewood
Samuel J. Lloyd, M.D. — Trenton
Nicholas E. Marchione, M.D. — Vineland
Jesse McCall, M.D. — Newton
Fred A. Mettler, M.D. — Blairstown
Richard I. Nevin, *Executive Director* — Trenton
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legislation
(1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 15 Senatorial Districts/21 Component Societies

Medicaid, New Jersey (Citizens) Committee for
(Established at request of organization — 4/21/68)
Louis K. Collins, M.D. — Glassboro

Medical Assistants, New Jersey Association of
(Liaison requested by Association — 9/15/63)
Aaron J. Heisen, M.D. — Trenton

Medical-Hospital-Nursing Conference (Tri-Partite)
(Liaison established by MSNJ — 1/13/57)
John F. Kustrup, M.D., *President* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Louis K. Collins, M.D., *Immediate Past-President* — Glassboro
Richard I. Nevin, *Executive Director* — Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)
(1) Medical-Dental
(Liaison requested by the Dental Society—6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)
John F. Kustrup, M.D., *President* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Louis K. Collins, M.D., *Immediate Past-President* — Glassboro
Richard I. Nevin, *Executive Director* — Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish A
(Established by Board — 5/17/67 — Appointments by President)
Louis K. Collins, M.D., *Chairman* — Glassboro
A. Guy Campo, M.D. — Westville
Joseph P. Donnelly, M.D. — Jersey City
Sherman Garrison, M.D. — Bridgeton
Frank J. Hughes, M.D. — Gloucester
Jerome G. Kaufman, M.D. — Maplewood
John F. Kustrup, M.D. — Trenton
Fred A. Mettler, M.D. — Blairstown

Medical Schools in New Jersey, Ad Hoc Committee on Development of
(Established by Board — 9/20/64)
John F. Kustrup, M.D., *President, Chairman* — Trenton
Nicholas A. Bertha, M.D., *President-Elect* — Wharton
Joseph P. Donnelly, M.D. — Jersey City
Sherman Garrison, M.D. — Bridgeton
Jerome G. Kaufman, M.D. — Maplewood
Fred A. Mettler, M.D. — Blairstown

Medical-Surgical Plan Board of Trustees
(Provided in MSP Bylaws)
John F. Kustrup, M.D., *President* — Trenton

Medicore Low (P.L. 89-97)

(Assigned by the Board — 10/17/65 as indicated below)

(1) Overall responsibility to study and provide recommendations concerning the Medicare Program
Council on Medical Services
Consultants to the Council on Medical Services:
John F. Kustrup, M.D., *President* Trenton
Nicholas A. Bertha, M.D., *President-Elect* Wharton
Jesse McCall, M.D., *Chairman, Council on Legislation* Newton
John P. Coughlin, M.D., *Chairman, Council on Public Health* Jersey City
Frank J. Hughes, M.D., *Member, New Jersey Board of Control* Gloucester

(2) Liaison representative to State Department of Health
(Established by MSNJ — 1/16/66)
David Eckstein, M.D. Trenton

(3) Liaison representatives to State Department of Institutions and Agencies
(Established by MSNJ — 1/16/66)
Francis J. Benz, M.D. Chatham
Louis K. Collins, M.D., *Chairman, Council on Medical Services* Glassboro
Vincent A. Maressa, *Executive Assistant* Trenton

(4) Home-Hospital-Nursing Care
(Liaison established by MSNJ — 3/20/66)
Matthew E. Boylan, M.D. Jersey City

Membership Directory

(Special committee established by Board — 11/19/61)

Marcus H. Greifinger, M.D., *Chairman* Newark
John J. Bedrick, M.D. Bayonne
Nicholas A. Bertha, M.D. Wharton
George B. Sharbaugh, M.D. Trenton
Joseph R. Jehl, M.D. Clifton
Richard I. Nevin, *Executive Director* Trenton
Robert H. Lambert, *Business Manager* Trenton

Motor Vehicles, State Division of

(Liaison established at the request of the Division — 4/16/61)
Chairman, Committee on Traffic Safety
Irwin S. Smith, M.D. Willingboro

Neurologicol Diseases, Advisory Council to New Jersey Consultotion Service for Convulsive Disorders

(Liaison established — 7/19/64)

Robert S. Garber, M.D. Belle Mead

New Jersey College of Medicine ond Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)
Joseph P. Donnelly, M.D. Jersey City

Nursing, Governor's Tosk Force on

(MSNJ representatives named to the Task Force)

Jesse McCall, M.D. Newton
William P. Mulford, M.D. Beverly
Richard I. Nevin, *Executive Director* Trenton

Nursing Educotion ond Recruitment, Permonent Committee on

(Established by direction of 1963 House of Delegates)

Jesse McCall, M.D., *Chairman* Newton
George E. Barbour, M.D. Somerville
William P. Mulford, M.D. Beverly
Lewis E. Savel, M.D. South Orange
Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)

S. William Kalb, M.D. Newark

OCHAMPUS (Office for the Civilion Heolth ond Medicol Progrom of the Uniformed Services)

(1) Fiscal Agent
(Designated upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey

(2) Special Committee on
(Established by MSNJ — 9/9/56)
Nicholas A. Bertha, M.D., *Chairman* Wharton
George E. Barbour, M.D. Somerville
Thomas C. DeCecio, M.D. Cliffside Park
Louis K. Collins, M.D. Glassboro

Osteopothic Question, Speciol Committee on

(Request by AMA — 11/19/62 . . . Reactivated by Board — 7/18/65)

Emanuel M. Satulsky, M.D., *Chairman* Elizabeth
John J. Bedrick, M.D. Bayonne
Louis K. Collins, M.D. Glassboro

Porents ond Teochers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)

Joseph R. Jehl, M.D. Clifton

Pension Plon, Speciol Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)

Thomas C. DeCecio, M.D., *Chairman; Chairman, Committee on Finance and Budget* Cliffside Park
John F. Kustrup, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* Trenton
Samuel J. Lloyd, M.D., *Treasurer* Trenton

Public Health Associotion, New Jersey

(1) Membership authorized by Board — 11/15/59
Joseph R. Jehl, M.D., *Delegate* Clifton
Richard I. Nevin, *Alternate* Trenton

(2) Animal (Medical) Research
(Liaison representative requested by Association — 4/17/66)
Edwin H. Albano, M.D. East Orange

(3) Medical Care Committee
(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)
John J. Bedrick, M.D. Bayonne

Public Heolth Council, Stote Deportment of Health

(Nominatons for appointment by Governor . . . requested — 9/20/64)

Henry L. Drezner, M.D. Trenton

Quockery, Committee on

(Established at the request of the AMA — 11/15/64)

Thomas C. DeCecio, M.D., *Chairman* Cliffside Park
Henry J. Mineur, M.D. Cranford
Charles B. Norton, M.D. Woodstown

Radiation Protection Commission, Consultant to New Jersey
(Nomination for appointment to Commission requested — 7/18/65)
Bernard M. Schnur, M.D. ..... Trenton

Radiation Protection Commission, New Jersey
(Two consultants in nuclear medicine requested by the Commission 11/66)
Frank Schell, M.D. ..... Paterson
John Thompson, M.D. ..... Caldwell

Regional Planning Council, Philadelphia Medical Library Committee
(Appointment of representative requested by Library Committee 8/20/67)
Sherman Garrison, M.D. ..... Bridgeton

Rehabilitation Commission, New Jersey State
(Liaison requested by MSNJ Committee on Rehabilitation — 5/65)
Carl A. Maxwell, M.D. ..... Phillipsburg

Safety Council, New Jersey State
(Provided in Council Bylaws)
John F. Kustrup, M.D., *President* ..... Trenton
Joseph A. Lepree, M.D., *President's Representative* ..... Elizabeth

Selective Service System, New Jersey Chairman of Advisory Committee to
(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Jesse McCall, M.D. ..... Newton

Statutes Related to the Practice of Medicine and Surgery in New Jersey, Committee to Review
(Established by MSNJ to implement substitute resolution 7 and 8, 1967 House)
Nicholas A. Bertha, M.D., *Chairman* ..... Wharton
Thomas C. DeCecio, M.D. ..... Cliffside Park
Samuel J. Lloyd, M.D. ..... Trenton
Richard I. Nevin, *Executive Director* ..... Trenton
E. Powers Mincher, *Acting Legal Counsel* ..... Pennington
Vincent A. Maressa, *Executive Assistant* ..... Trenton

Tuberculosis Council, New Jersey State
(Appointment of representative to council requested by Commissioner of Health — 2/19/61)
John P. Coughlin, M.D. ..... Jersey City

Welfare Council, New Jersey
(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)
John J. Bedrick, M.D. ..... Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of
(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. ..... Clifton

OBITUARIES

Dr. David L. Andrus

At the early age of 62, Dr. David L. Andrus died on July 9, 1968. Dr. Andrus was a leading cardiologist and internist in South Jersey, a Fellow of the American College of Cardiology, and the cardiologic consultant at the Camden County Chest Hospital in Lakeland. He received his M.D. degree at Hahnemann in 1931. Dr. Andrus was chief of cardiology at the West Jersey Hospital in Camden at the time of his death.

Dr. Archie W. Johnson

An active internist in the Jersey City area, Dr. Archie W. Johnson died on July 24, 1968 at the age of 63. Respected by patients and associates alike, he contributed much to civic affairs in his community and was continually furthering his medical knowledge by graduate study to better serve in his chosen field. Dr. Johnson was a graduate of Howard University Medical School in 1934.

ANNOUNCEMENTS

Ulcerative Colitis Symposia

"Autoimmune Hemolytic Anemia Complicating Ulcerative Colitis" is the general topic for two symposia — one on ulcerative colitis and the other on anorectal fistulas — to be presented by the Pennsylvania Society of Colon and Rectal Surgery on the evening of September 13th at the Union League, Broad and Samson Streets in Philadelphia.

The guest speaker will be Lyndall Molthan, M.D., Associate Professor of Medicine at Temple University. One of MSNJ's outstanding proctologists, Dr. George L. Becker of Paterson, will be moderator for the symposium on anorectal fistulas, and Dr. Harry E. Bacon of Philadelphia will preside at the discussion on ulcerative colitis. Other participants, in alphabetical order, include Drs. J. Edwin Alford of Buffalo, Francis J. Burns of St. Louis, Patrick H. Hanley of New Orleans, Benjamin Haskel of Philadelphia, Herbert T. Hawthorne of Bryn Mawr, Andrew J. McAdams of Pittsburgh, Norman D. Nigro of Detroit, William H. Ramsey of Bryn Mawr, and Robert J. Rowe of Dallas. The scientific session is scheduled for 8 p.m., preceded by cocktails and dinner at 6 o'clock. Reservations may be made directly with Valentine R. Manning, Jr., 3336 Aldine Street, Philadelphia. The fee is $15.

Courses In Hypnosis

Columbia University College of Physicians and Surgeons announces its annual graduate course in *Medical Hypnosis,* under the direction of Herbert Spiegel, M.D., to be held Saturdays 10 a.m. to 5 p.m., October 5 to November 16, 1968. Lectures, case demonstrations, practice sessions, movies, and seminars are designed to present technics and theories of hypnosis and to demonstrate the adjunctive uses of hypnosis in clinical medicine. It is open to general practitioners and specialists.

This is followed by *Hypnosis and Psychiatry* and is open only to psychiatrists who have taken the basic hypnosis course or the equivalent. Lectures, seminars, and case material are presented to show hypnosis can facilitate the psychotherapeutic process — four Saturdays 10 a.m. to 5 p.m., January 4 to 29 in 1969.

For information write to: Melvin D. Yahr, M.D., Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York, New York 10032.

Upper Gastrointestinal Bleeding

You are welcome to attend a symposium on upper gastrointestinal bleeding to be held at 3:30 p.m. on Wednesday, October 9th in the Conference Room of the Montclair Community Hospital (1st floor, north wing).

The speakers will include Irving M. Enquist, M.D., Professor of Surgery at New York State College of Medicine and Vernon M. Smith, M.D., Professor of Clinical Medicine at the University of Maryland. Eddy D. Palmer, M.D., Professor of Medicine at the New Jersey College of Medicine, will be the moderator. The program is approved for 3 hours by AAGP.

After the session there will be a round table discussion and dinner at Rod's, 525 Northfield Avenue, West Orange. The dinner includes cocktails and the cost is $15 for guests. There is no charge for attending the symposium.

Diabetes Symposium

The New York Diabetes Association Clinical Society announces the 16th annual symposium to be held on Saturday, October 12, 1968, at the Barbizon-Plaza Hotel, Central Park South, New York City. Theme of the Symposium will be "Genetic and Environmental Factors in Diabetes Mellitus."

The morning program begins at 9 o'clock and includes talks by Nancy E. Simpson, Ph.D., Queen's University, Kingston, Ontario— "General Genetic Aspects of Diabetes;" David L. Rimoin, M.D., Washington University School of Medicine, St. Louis — "Is Diabetes A Heterogeneous Group of Disorders?;" Robert E. Greenberg, M.D. and Norman Kretchmer, M.D., Stamford University Medical School — "Environmental Modifications of Carbohydrate Metabolism."

The afternoon program is scheduled for 1:45 and the speakers will be M. G. Herrera, M.D., Harvard School of Public Health—"The Physiology of Starvation Diabetes"; B. W. Volk, M.D. and Sydney S. Lazarus, M.D., Isaac Albert Research Institute—"Experimental Aspects of Diabetes Mellitus"; I. Arthur Mirsky, M.D., University of Pittsburgh— "What Is Diabetes Mellitus?"

For more details write to the New York Diabetes Association, 104 East 40th Street, New York, New York 10016.

Nutritional Problems In Medicine

The Committee on Nutrition and Metabolism of the Philadelphia County Medical Society is holding its 13th Annual Conference October 23, 1968 in the auditorium of Temple University Medical Center. Highlight of the conference is an address by Professor John Yudkin, University of London (England) on the role of nutrition in cardiovascular disease.

The afternoon session is devoted to workshops on nutritional and metabolic aspects of (1) renal disease, (2) diabetes mellitus, (3) preventive cardiovascular disease and (4) malabsorption syndrome.

For further information, write to Dr. Michael G. Wohl, Committee on Nutrition and Metabolism, Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia 19130.

Pediatric Allergy Course In Philadelphia

You can attend a practical graduate course and symposium on allergy in childhood. This is a two-day symposium on November 6 and 7, 1968. It is sponsored by St. Christopher's Hospital and the Children's Heart Hospital, both of Philadelphia. AAGP credit is given. For more details, write to Dr. Leonard Girsh, Children's Heart Hospital, 3701 North Broad Street, Philadelphia 19140.

Colloquium On Compensation Medicine

On November 7 and 8, 1968 a conference will be held on surgical and medical problems in workmen's compensation cases. Sponsored by the Academy of Compensation Medicine, this meeting will be at New York University Medical Center. Foci will be on eye injuries, cardiovascular problems, cerebrovascular disorders and causes of failure in disc surgery. For details, write to Academy of Compensation Medicine, Box 180, New York, New York 10019. No registration fee will be charged.

Honolulu In 1969

Don't look at your 1969 appointment book yet, but here is a chance to visit Hawaii in the course of the pursuit of knowledge. The American College of Surgeons convenes in San Francisco October 6 to 10 in 1969. And on October 14 there will be a meeting in Honolulu which you (even if you are not a FACS) may attend.

The scientific program will include 300 speakers in most surgical specialties. Concurrent meetings will be held on colon and rectal surgery, general surgery, neurosurgery, obstetrics, gynecology, thoracic-cardiovascular surgery, urology, anesthesiology, and radiology. All scientific meetings will be held in the morning, leaving afternoons free for sightseeing and social events.

Bring your family to take advantage of this combined scientific meeting and family holiday. If 1969 comes and goes without your making this trip, don't say we didn't warn you.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968

September

16-20 **The Academy of Medicine of New Jersey, The American Academy of General Practice, and Newark Beth Israel Hospital**
Basic Vectorelectrocardiography

18 **The Academy of Medicine of New Jersey**
Hoffmann LaRoche Inc.
Nutley
Symposium: "The Moment of Death"

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

24 **Hunterdon County Medical Society**

30 **Cape May County Medical Society**

October

1 **Hudson County Medical Society**

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Essex County Medical Society**
Combined Dinner Meeting with Auxiliary
"Sex Education in the Schools"

9 **Gloucester County Tuberculosis and Health Association**

9 **Middlesex County Medical Society**

9 **Montclair Community Hospital**
Symposium: "Massive Upper Gastrointestinal Bleeding"

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **The Academy of Medicine of New Jersey**
Hotel Robert Treat
Newark
Symposium: "Antisocial Personality: The Physician's Responsibility"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **New Jersey Gastroenterology Society**
Veterans Administration Hospital
East Orange

23 and 30 **The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital**
"Coronary Artery Disease"

30 **New Jersey Society of Internal Medicine**
Hoffmann LaRoche Inc.
Nutley

November

5 **Hudson County Medical Society**

6 **The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital**
"Coronary Artery Disease"

8 **New Jersey Academy of Science**
Rutgers University
New Brunswick
Symposium: "Influence of Cold on Metabolic Regulation"

12 **Bergen County Medical Society**

13 **The Academy of Medicine of New Jersey**

The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 Gloucester County Tuberculosis and Health Association

13 Middlesex County Medical Society

13 Ocean County Medical Society

13 American College of Physicians
New Jersey Regional Meeting
Rutgers University Medical School

14 Essex County Medical Society

20 New Jersey State Dental Society
Semiannual Session

21 Gloucester County Medical Society

21 Morris County Medical Society

25 Cape May County Medical Society

26 Hunterdon County Medical Society

December

3 Hudson County Medical Society

5-6 The Academy of Medicine of New Jersey
Section on Obstetrics and Gynecology
Newark City Hospital
Workshop on Culdoscopy

7 American College of Surgeons, New Jersey Chapter
Annual Meeting
Newark Beth Israel Hospital
Newark

10 Bergen County Medical Society

10 Cumberland County Medical Society

11 The Academy of Medicine of New Jersey
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

11 Gloucester County Tuberculosis and Health Association

11 Middlesex County Medical Society

11 Ocean County Medical Society

26 Gloucester County Medical Society

26 Morris County Medical Society

1969
January

7 Hudson County Medical Society

8 Gloucester County Tuberculosis and Health Association

8 Middlesex County Medical Society

8 Ocean County Medical Society

14 Bergen County Medical Society

16 Gloucester County Medical Society

16 Morris County Medical Society

22 The Academy of Medicine of New Jersey
Overlook Hospital
Summit
Symposium: "Coronary Care"

27 Cape May County Medical Society

28 Hunderton County Medical Society

February

4 Hudson County Medical Society

11 Bergen County Medical Society

11 Cumberland County Medical Society

12 Gloucester County Tuberculosis and Health Association

12 Middlesex County Medical Society

12 Ocean County Medical Society

14-15 American College of Surgeons

18 Warren County Medical Society

19 The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division
Symposium: "What's New in Cancer"

20 Gloucester County Medical Society

20 Morris County Medical Society

26 New Jersey Academy of General Practice
Convention
Sheraton-Deauville Hotel
Atlantic City

March

4 Hudson County Medical Society

7-9 The Academy of Medicine of New Jersey and Bergen Pines County Hospital
Bergen Pines County Hospital
Paramus
"Current Concepts in Respiratory Disease"

11 Bergen County Medical Society

12 Gloucester County Tuberculosis and Health Association

12 Middlesex County Medical Society

12 Ocean County Medical Society

19 The Academy of Medicine of New Jersey
Symposium: "Management of Gastrointestinal Hemorrhage"

20 Gloucester County Medical Society

20 Morris County Medical Society

25 Hunterdon County Medical Society

31 Cape May County Medical Society

April

1 Hudson County Medical Society

2 The Academy of Medicine of New Jersey
Symposium on Gynecology

8 Bergen County Medical Society

8 Cumberland County Medical Society

9 Gloucester County Tuberculosis and Health Association

9 Middlesex County Medical Society

9 Ocean County Medical Society

15 Warren County Medical Society

16 The Academy of Medicine of New Jersey
Dental Symposium
VA Hospital, East Orange

17 Gloucester County Medical Society

17 Morris County Medical Society

26 Kessler Institute of Rehabilitation
20th Anniversary Dinner

1969
May

6 Hudson County Medical Society

13 Bergen County Medical Society

14 Gloucester County Tuberculosis and Health Association

14 Ocean County Medical Society

15 Gloucester County Medical Society

15 Morris County Medical Society

17-21 MSNJ Annual Meeting

20 Warren County Medical Society

26 Cape May County Medical Society

28 Middlesex County Medical Society



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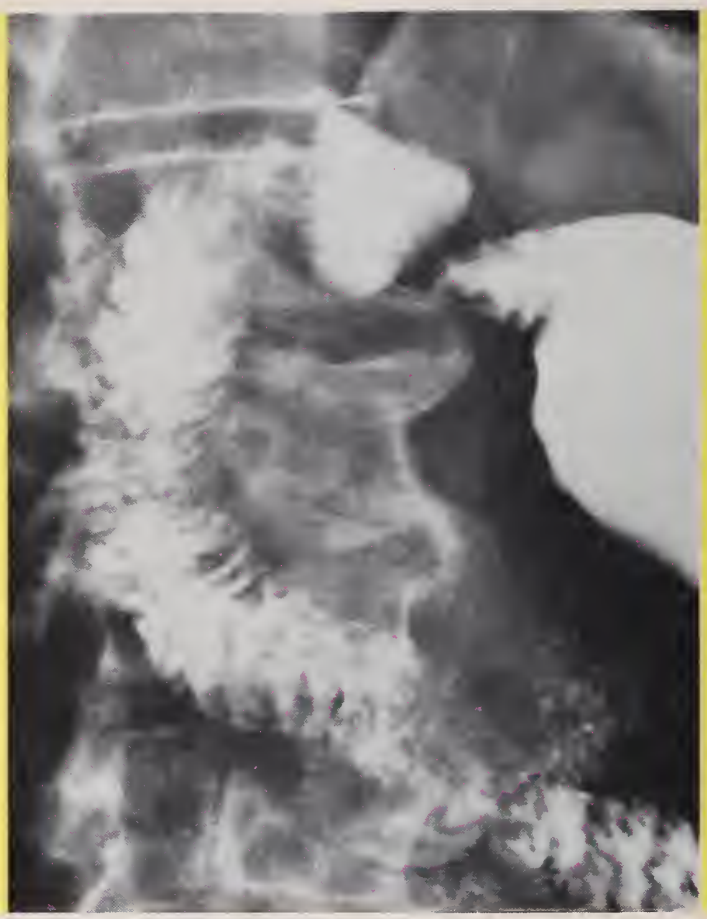
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For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in facilitating diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis, and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

...AT REST



SAME DUODENUM—(Hypotonic X-ray) Pro-Banthine-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

Contraindications: Glaucoma; severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. 50:445-460 (May-June) 1955.

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cine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
obarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

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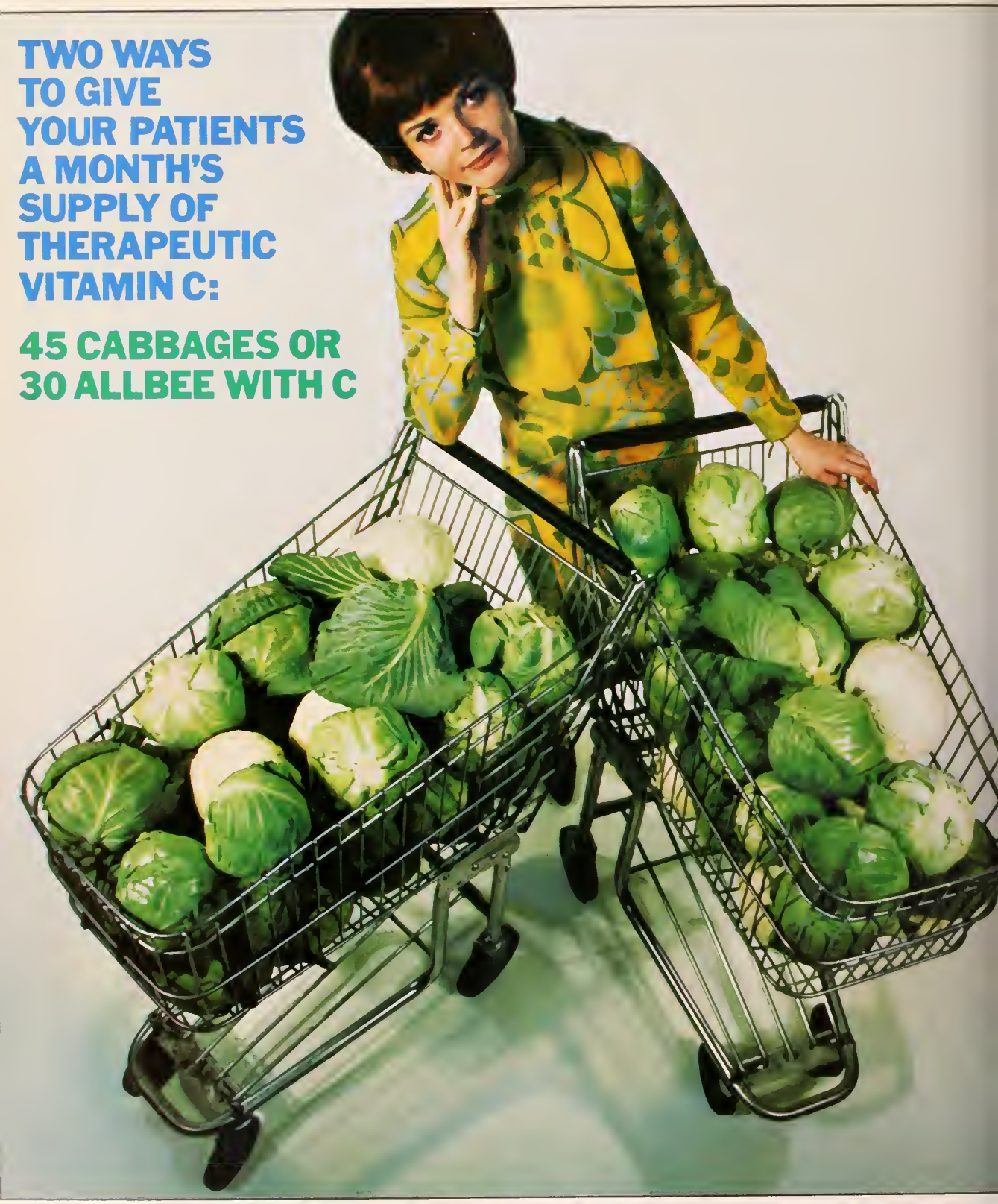
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Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



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Brief Summary

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10 mg. Methamphetamine Hydrochloride,
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Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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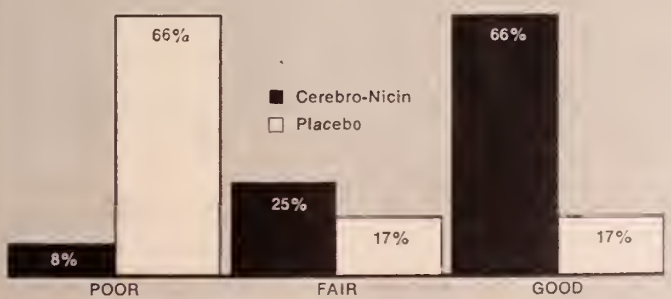
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jr.M.D., of the Amer. Ger. Soc. June, 1964

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DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a tingling or flushing sensation after taking a higher potency niacin containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of therapy. If the patient is forewarned of the reaction

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin type anticoagulants are given simultaneously watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles face may be minimized by withholding diet salt, reduction in dosage or use of diuretic In elderly patients and in those with hypertension, the drug should be discontinued w the appearance of edema. The drug has be associated with peptic ulcer and may reac

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ate a latent peptic ulcer. The patient should e instructed to take doses immediately after neals or with milk to minimize gastric upset. rug rash occasionally occurs. If it does, romptly discontinue the drug. Agranulocyosis, exfoliative dermatitis, Stevens-Johnson yndrome, Lyell's syndrome (toxic necrotizng epidermolysis) or a generalized allergic eaction similar to a serum sickness synrome may occur and require permanent ithdrawal of medication. Agranulocytosis an occur suddenly in spite of regular, reeated normal white counts. Stomatitis, saliary gland enlargement, vomiting, vertigo and anguor may occur. Leukemia and leukemoid eactions have been reported. While not definitely attributable to the drug, a causal relaionship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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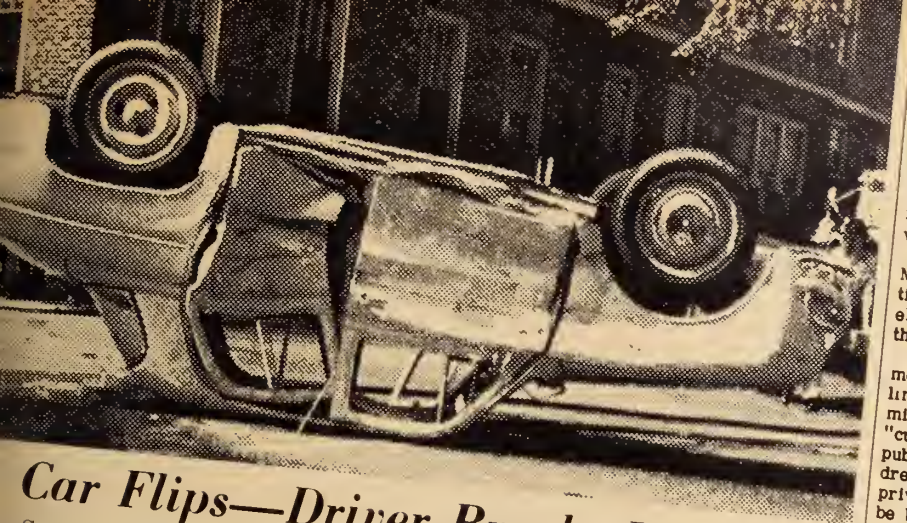
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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in m instances by proper dosage adjustment, b also occasionally observed at the lower do ranges. In a few instances syncope has be reported. Also encountered are isolated i stances of skin eruptions, edema, minor r strual irregularities, nausea and constipat extrapyramidal symptoms, increased and creased libido—all infrequent and genera controlled with dosage reduction; change EEG patterns (low-voltage fast activity) m appear during and after treatment; blood crasias (including agranulocytosis), jaun and hepatic dysfunction have been report occasionally, making periodic blood coun and liver function tests advisable during tracted therapy.

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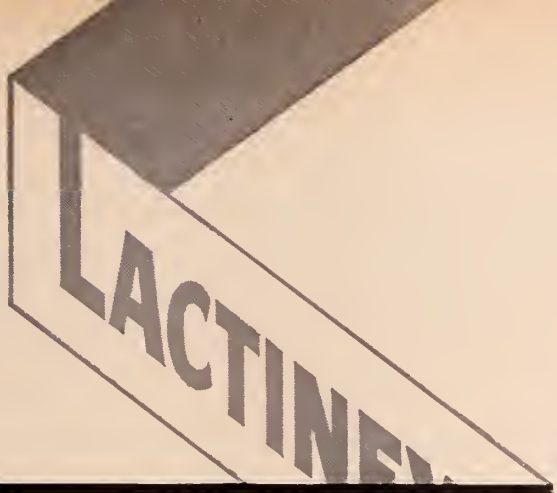
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■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

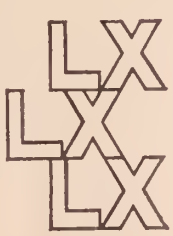
References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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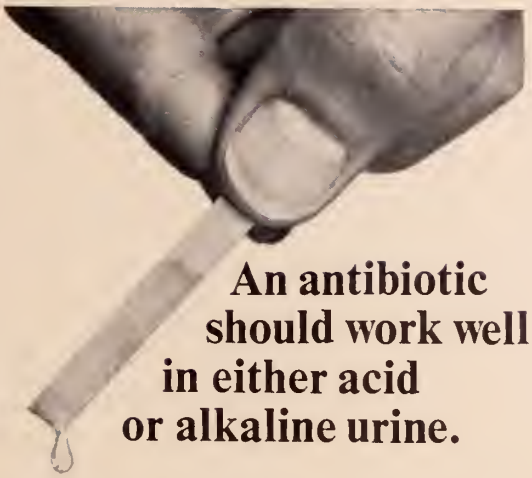
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An antibiotic should work well in either acid or alkaline urine.

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Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

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To the Members of The Medical Society of New Jersey:

A recent article in "The Health Digest", published by the Voluntary Health Insurance Council of Australia, was of great interest to me and I thought a short synopsis might be of interest to all practicing physicians.

Australia and Great Britain have taken virtually opposite roads in providing health care to their people. The Australian system is basically a fee for service and voluntary health insurance approach with the government subsidizing those people who are unable to pay the full cost of their voluntary insurance. In Great Britain health services are provided, broadly speaking, by the government and financed by taxation.

A survey was made of 360 doctors who had left Great Britain to practice in Australia. Of the respondents, 85% said they would never practice under the British National Health Service again; 70% said the British system led to an unsatisfactory standard of service to patients; 90% said it created an unsatisfactory relationship between the doctor and patient.

On the subject of voluntary health insurance, 86% declared the principle a sound one (with the understanding that the government would subsidize the care of the medically indigent by payment of the voluntary plans). A free enterprise system with a choice of health insurance promotes greater efficiency than other systems, 79% felt, and virtually the same percentage found the British system inefficient.

Some 80% of the doctors commented that they were happier practicing in Australia, were more efficient, and were giving their patients far better care than had been possible in Britain.

It is obvious that these Australian physicians who previously practiced under National Health Insurance in England are far happier with a private system of medical care, and they also believe it provides better health care for their patients.

Some of you will recall that in 1944 there was an all-out effort to pass the Wagner-Murray-Dingell Bill which would have nationalized health care in this country. The American Medical Association, State Medical Societies, Blue Shield and Blue Cross Plans and other voluntary insurance plans were in the forefront of the battle against this Bill, which never passed. Since that time there have been many changes in the practice of medicine, but the people of the United States have never adopted a form of National Health Insurance because they realized that a system of private medical care with a close doctor-patient relationship was worth preserving. The New Jersey Blue Shield Plan is proud of the contribution it has made in the preservation of our present system of medical care, but it fully realizes that without the cooperation of the medical profession its efforts would have been in vain.

With your continued assistance we are confident that we can continue to provide the people of New Jersey with excellent private medical care at a price they can afford, and this is the best guaranty there is for the continuation of a system of private medical care in this country and a strong defense against any new proposals for National Health Insurance.

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A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

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(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
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LONG-ACTING (6-8 HOURS)			●	
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(even ours) to do that!



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For smooth appetite control plus mood elevation

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Methamphetamine Hydrochloride
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10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



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The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



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Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

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Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

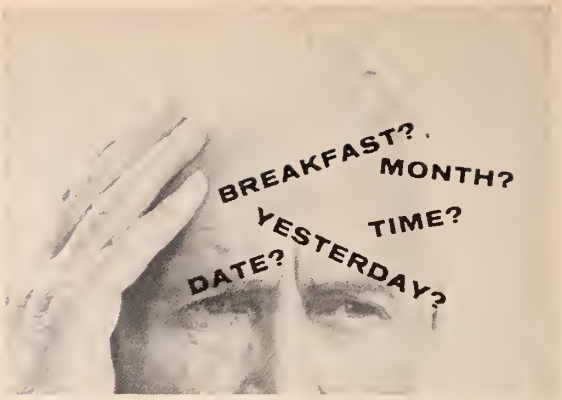
Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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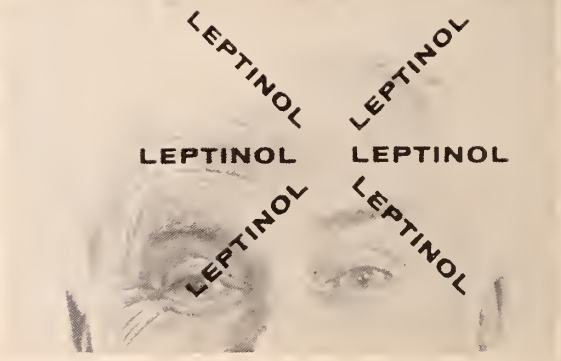
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When elderly patients display symptoms of apathy, mental confusion, memory lapses...

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LEPTINOL®



LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses. It is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day. Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

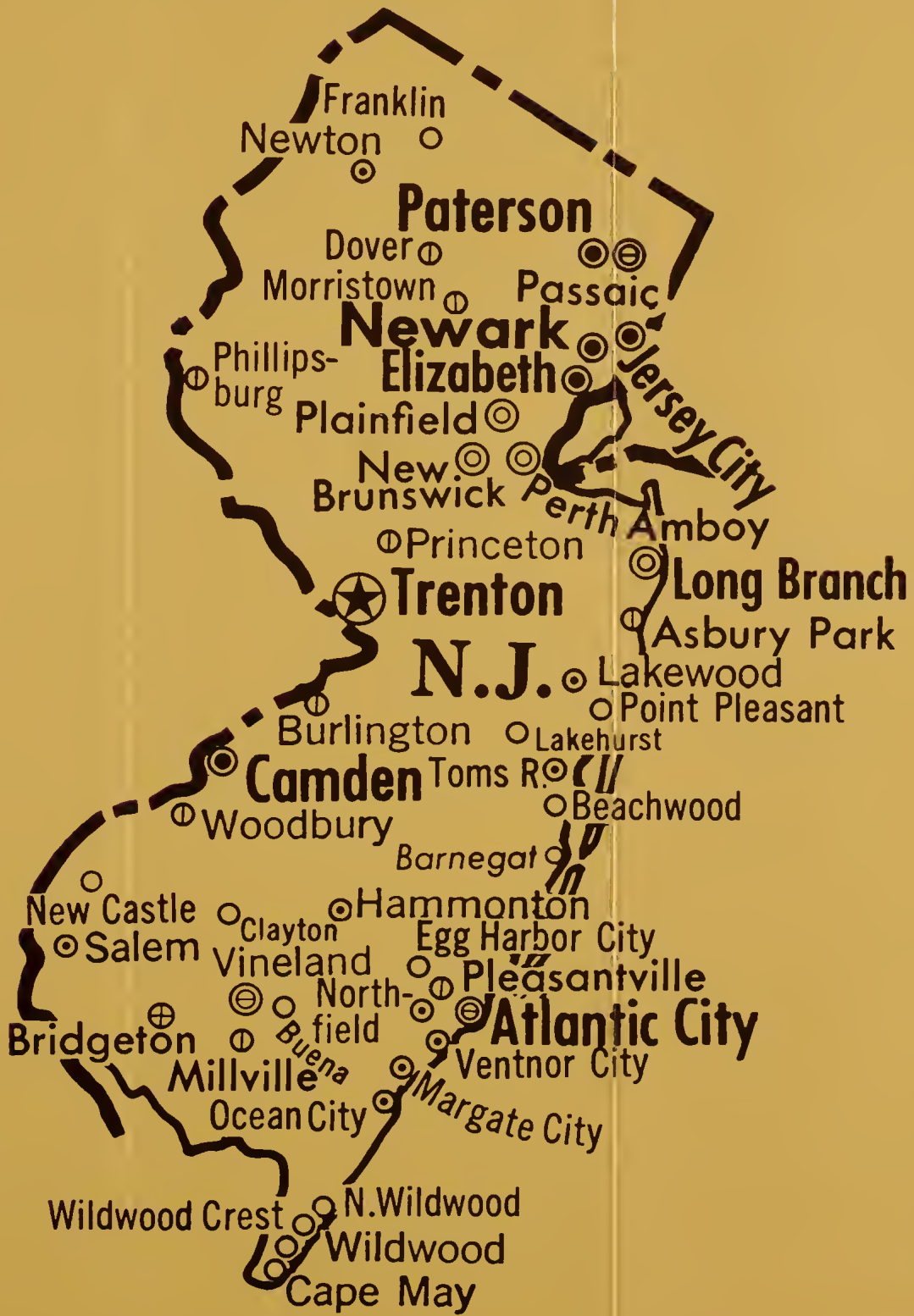
Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

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TETRACYCLINE



Co., Inc., New York. No. NY 388

See inside fold for product summary.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

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TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle
LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg of phenylpropanolamine hydrochloride, and 2.5 mg of isopropamide, as the iodide

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French, Laboratories

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg.
Glutamic Acid . . . . . 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen – only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. **DOSE** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

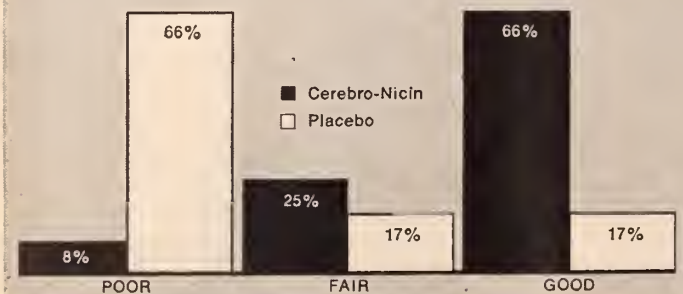
For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:
Pentylenetetrazole . . . . . 100 mg.
Nicotinic Acid . . . . . 100 mg.
Ascorbic Acid . . . . . 100 mg.
Thiamine HCl . . . . . 25 mg.
l-Glutamic Acid . . . . . 50 mg.
Niacinamide . . . . . 5 mg.
Riboflavin . . . . . 2 mg.
Pyridoxine . . . . . 3 mg.

DOSAGE One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

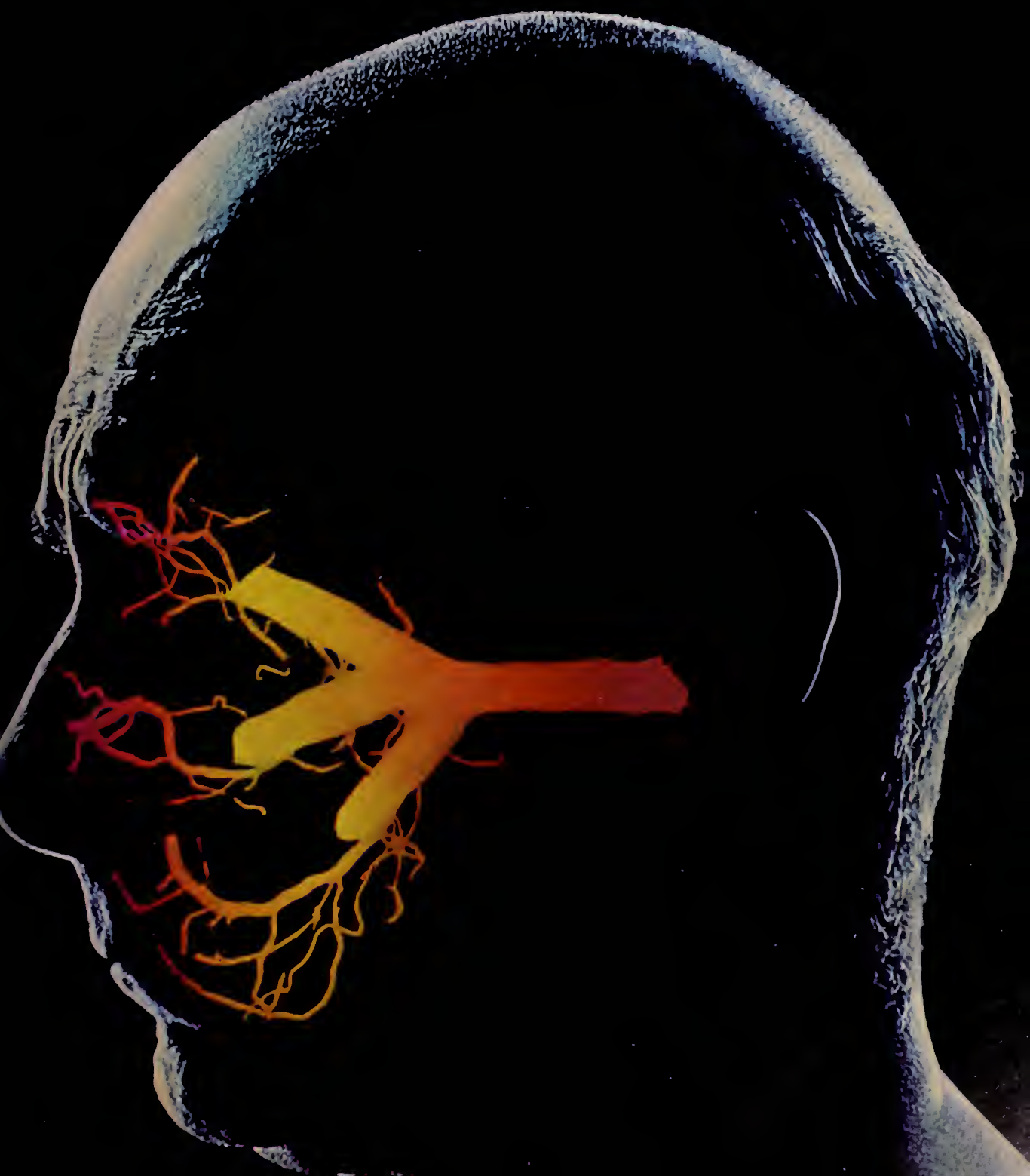
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dr should be discontinued.
2. Liver function tests must be performed at regular intervals during tr ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tono etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities i liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryth multiforme and nodosum, aggravation of disseminated lupus erythema tosus, gastric distress, abdominal pain, diarrhea, constipation, anorexi dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hyp tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular eff are drug-related is not known. However, some of these complications h resulted in fatalities.) The necessity for discontinuing the drug should b dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with mea if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the d should be increased in one-half tablet (100 mg.) increments every 12 h until freedom from pain is achieved. To relieve pain, between 200 mg. a 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should b made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geig

uncommon relief of uncommon pain



The Divorced Depressive: "Forty Forgotten

"Had a large wedding."
"Had a fine home and family."



TO-5757

Forlorn"

Had a divorce."
'm a real loser,
and so are
he kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofranil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofranil can often help prevent relapse.

The use of Tofranil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy – the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofranil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofranil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

The Medical Society of New Jersey

Loss Control Program

ENDORSED LIABILITY POLICIES

Professional Liability for physicians, partnerships, hospital emergency-room groups, and employed nurses, technicians, or aides.

Professional Premises Liability which, when placed with the same company insuring professional liability, eliminates the possibility of controversy when a patient is injured on the premises.

Personal Catastrophe, commonly known as **Excess Liability or Umbrella** coverage, with protection of an additional $1,000.00 over other insurance such as automobile, home, sports, personal, professional acts, and professional premises liabilities. It also covers uninsured liabilities, with a minimum deductible of $250.00 applying only to uninsured liabilities.

Libel, Slander, Defamation of Character coverage for officers, employees, and committee members of medical societies.

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Not Just "Milk" But . . .

WALKER-GORDON CERTIFIED MILKS

There are many reasons why thousands of discriminating families have been raised from infancy on Walker-Gordon Certified Milks. Among the reasons:

- *Super-Sanitary Production Methods.* From cow to bottle, milk is never exposed to air or human touch.
- *Cleanest.* Lowest bacteria count. Laboratory on the farm.
- *Freshest.* Bottled immediately after milking, usually delivered the following day. Keeps for weeks under normal refrigeration.
- *Uniform.* No variance in flavor or nutritional value, 365 days a year.

Guaranteed Free of Antibiotic Residue

Certified Milks available through Leading Milk Dealers: Raw, Homogenized-Vitamin D, Skimmed, Fresh Lo-Sodium. Write for complete information.

WALKER-GORDON CERTIFIED MILK FARM

Plainsboro, N.J. ***(Area Code 609) 799-1234***

NEW YORK: 212 WAlker 5-7464 ★ PHILA.: 215 MArket 7-6338

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

ROERIG Rx
J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J.B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

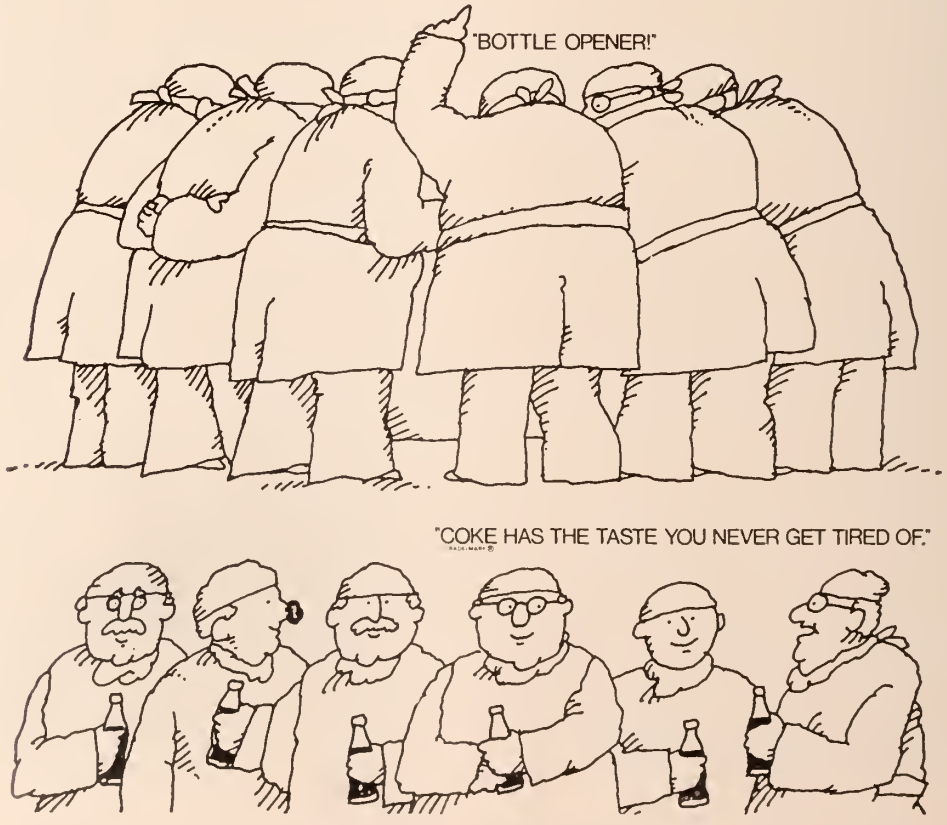
Cash Lacks Interest,
. . . here it earns it.

4½% on Regular or 5%
on Investment Bonus
Savings Accounts

Call or visit us for details

Orange Savings Bank

MAIN OFFICE – Main and Day St. ESSEX DRIVE-IN OFFICE – So. Essex Ave. at Henry St.
Member F.D.I.C.



"COCA-COLA AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY



Is it depression?
He says "It's my stomach..."

...but his other symptoms:
functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt
strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

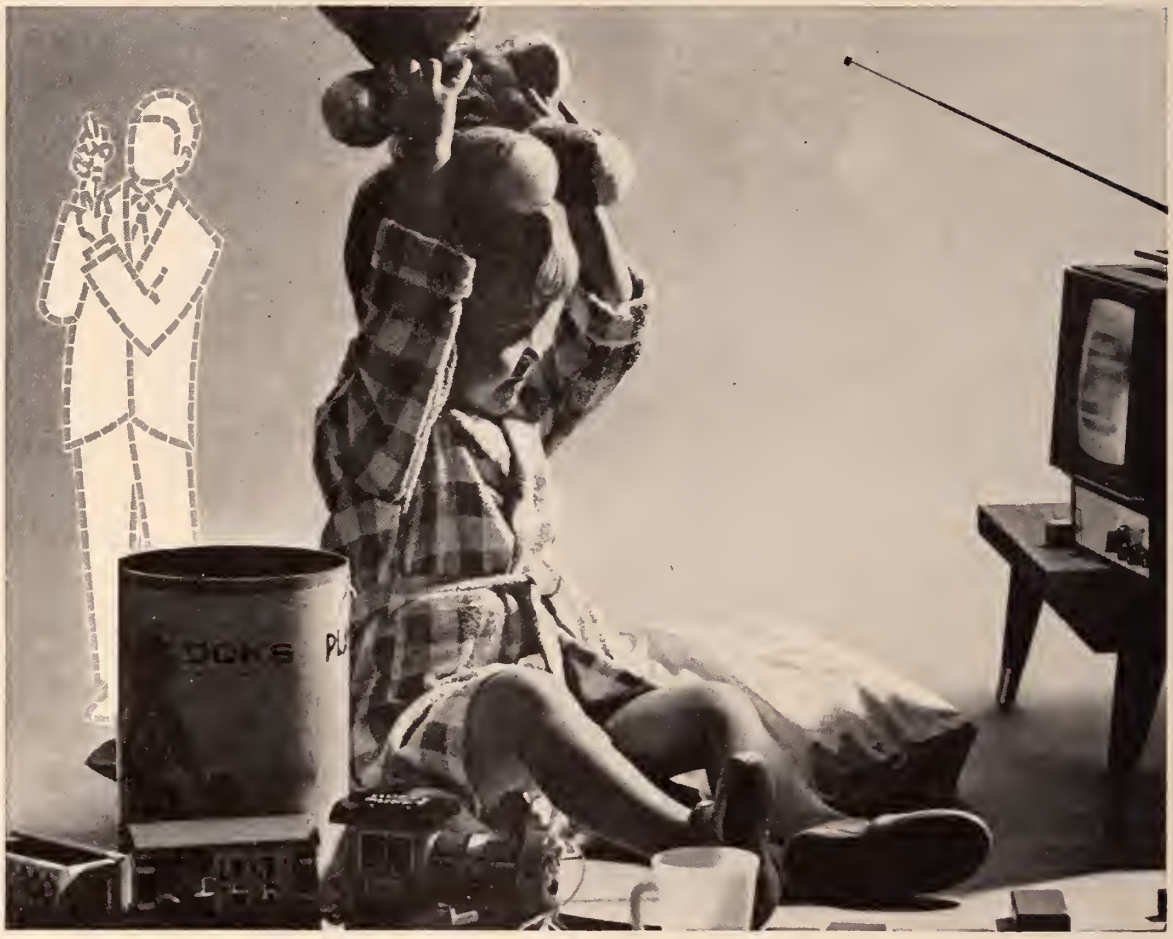
Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

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Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800197

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EDITORIALS

Miami In December

At no time in medical history has there been such an explosion of scientific knowledge and technology. And never has there been a greater demand for physicians' services. All this combines to burden the physician in his efforts to keep abreast of the modern developments in medicine. We are inundated with fine scientific publications, but exhausting hours of reading would be required to learn what can be gained by attending the Clinical Convention of the American Medical Association at Miami Beach, the first week in December.

Here you will see 125 exhibits reflecting the latest developments in pharmaceuticals, medical equipment, and scientific endeavors. The AMA's famous clinical conventions represent wonderful ways of providing continuing education to the medical practioner. The scientific exhibits alone are a good graduate course.

Special graduate courses will be offered in diabetes, fluid and electrolyte balance, and thyroid disease. In addition, there will be 30 medical motion pictures. Scientific television programs will be shown live and in color. You can attend clinical workshops and breakfast roundtables.

The AMA Clinical Convention is designed primarily for the man in practice. The speakers will read papers that will bring to the practitioner the latest findings of others in his area. There is an unprecedented emphasis on and need for continuing education. A great manpower shortage has made it mandatory for the physician to expand his knowledge and become more versatile.

The Clinical Convention promises to be a stimulating four days, worthy of the busy physician's time. You are urged to take advantage of this opportunity.

Self Restraint Or Government Compulsion?

We don't like the idea of any Government official telling us what we may prescribe, in what dose, and for what indication. Any official who tries to do that is at least a bureaucrat and maybe a tyrant. We say that we are intelligent and devoted enough to police ourselves as we do, for example, through the State Boards of Medical Examiners, through Blue Shield, and through medical school faculties.

Here now is a test case. On page 559 of this issue we have some material on the dangers of chloramphenicol, and the doubly poignant tragedy when death occurs after the drug is prescribed for a trivial ailment. Consider the problem that the Food and Drug Administration has in trying to monitor this. You are asked (through this notice, and through a "Dear Doctor" letter put out by the FDA) to show some restraint in prescribing chloramphenicol. Here is some comment made by James L. Goddard, M.D. in talking about this problem:

"Estimates place the incidence rate of blood dyscrasias from chloramphenicol at one person in ten thousand to one person in one hundred thousand who receive the drug. Yet the use of the drug continues to be excessive. Where have the FDA, the manufacturer, and the medical profession failed? Is the general medical community unaware of, or unconcerned about, the risks associated with this drug? "Box warning" in the labeling is strongly worded and tells the physician quite bluntly the dangers of the drug. Yet it has not accomplished its intended purpose.

"What other steps might be taken? We have considered restricting the use of chloramphenicol to hospitals. However, it appears that more than half the chloramphenicol distributed in this country is purchased by, and presumably used in, hospitals. Also, any restriction of the drug to hospital use alone would pose an undue hardship on some patients for whom the drug is properly prescribed. There are fewer than 1,000 cases of typhoid fever in this country each year, but most occur in rural areas which may not be served by hospitals and a few patients may require continual use of the drug after their hospital discharge. Some persons, therefore, would be deprived of appropriate treatment unless they undergo the inconvenience and expense of a hospital confinement.

"Other measures have been suggested, such as requiring that every prescription for chloramphenicol be countersigned by a second physician, or requiring permission by a board of physicians before the drug could be used. Such measures are not practical, desirable, or possible to enforce.

"It has also been suggested that chloramphenicol be restricted to use by physicians registered with the government in much the same way that narcotics are handled. This is not particularly desirable. Most drugs are potentially dangerous, even when properly used, and where should the line be drawn? Establishing this group of "dangerous drugs" will create more problems than it would solve. Would you want this?"

Some have tried to cope with the problem by insisting on more detailed records. Indeed, in an effort to regulate this, it has been proposed that the practitioner send records to the AMA or the Food and Drug Administration or the Public Health Service or a local health department, detailing every dose he prescribed, when, where, for what, and for whom. Doctors obviously don't want *that.*

So the next move is ours. Do we monitor this ourselves, do we respond to appeals to reason, self-interest, and the safety of patients? Or do we ask Big Brother to come in and do it for us?

Mail Order Medicine

One way of turning over a fast buck is to establish a mail-order medical service. The post office does its best to put out of business every mail-order fraud it can prove. But because of the general presumption of innocence, the burden of proof is on the complainant. Furthermore, victims are loath to admit that they have been guyed.

Glance through the pages of magazines addressed to the less literate fragments of the public. You will see advertisements of trusses, eye-glasses, sedatives, stimulants, vitamins, aphrodisiacs, massage equipment, denture glue, hay-fever alleviators, "analytical laboratories," hemorrhoid therapies, psoriasis cures, and the like. It is hard for the physician to shout too loudly against these, for when he does, the average retort is likely to be that the doctor is worried about "competition." Thus, it costs $25 or $50 to have a neurologic examination and perhaps $15 for every revisit. But if the patient has "spells," he can be "taken care of" at only $3 for a month's supply of "fit-control medicine." You and I know the hazards, but somehow we have failed to communicate them to the less sophisticated part of the public.

Don't say: there ought to be a law. There *is* a law. To enforce it, however, the authorities need names, dates, documents, and complainants who are willing to take an oath.

The Public Esteem Score

Elsewhere in this issue [page 570] we publish a list of the public's confidence in various professional groups, based on a Harris survey, published in *Newsweek*. This puts doctors of medicine at the top of the list—substantially above Supreme Court justices and clergymen.

Since the M.D. seems to be a favorite whipping boy today, one wonders about this apparent paradox. Physicians are being charged in books, speeches, columns, and news reports with greed, arrogance, indifference, and excessive incomes.

The difference in a person's appraisal of *his* physician and his evaluation of the medical profession generally is the difference between the concrete and the abstract. Doctors *en masse* have apparently been given a bad name. We certainly have more critics than many other professional *groups*. But the individual practitioner, as seen through the eyes of his patient, fares rather well.

There is one interesting lesson to be drawn from this. It's an old idea, of course—but it's still sound. The best public relations instrument in our profession is not an expensive professional firm, not eloquent releases to the press, but simply the conduct of each of us as an individual. The computers can calculate what we ought to do to refurbish our public image. But in the last analysis, there is nothing to beat the individual doctor's attitudes and actions—which speak louder than even the highest priced public relations professional on Madison Avenue.

ORIGINAL ARTICLES

An intramuscularly administered steroid was here found to be exceptionally effective in previously refractory allergic patients.

Clinical Evaluation Of An Intramuscularly Administered Steroid (Triamcinolone Acetonide)*

Christopher H. Demos, M.D./Somerville; Murray L. Maurer, M.D.†/New York

The corticosteroids are firmly established as valuable agents for the acute allergic process. The effectiveness of these steroids is now accepted as is the occurrence of adverse effects after oral administration. The intramuscular route of administration has certain advantages over the oral route and has been used increasingly in recent years.

Triamcinolone acetonide* is a synthetic corticosteroid with marked anti-inflammatory, antipruritic, and antiallergic properties. Chemically, it is fluoro-isopropylidenedioxy-delta-hydrocortisone. Clinical experience has established it as one of the most effective of the available topical corticosteroids.[1,2] Triamcinolone acetonide* as an aqueous suspension containing 10 mg/ml has been successfully administered by intralesional injection in dermatologic disorders[3,5,6] and by intra-articular injection in rheumatic diseases.[1,7,8]

In recent studies, triamcinolone acetonide,* as a 40 mg/ml aqueous suspension, has been administered intramuscularly to patients with rheumatic,[11,13] dermatologic,[9,10] and allergic conditions.[4] Intramuscularly, triamcinolone acetonide* has a very prolonged duration of action and provides systemic corticosteroid therapy with a minimum of adverse effects. This report presents data on the usefulness of this preparation in the treatment of allergic disorders.

One hundred forty patients (including 63 females) with a variety of allergic diseases were studied. Ages ranged from 5 to 79 years. Although 55 per cent were treated for more than one allergic condition, they are classified in Table I according to the major condition.

TABLE I

Condition Treated	*Total*	*Male*	*Female*
Pollenosis	45	21	24
Bronchial Asthma	44	24	20
Allergic Rhinitis (including Nasal Polyps)	34 (13)	22 (10)	12 (3)
Miscellaneous including—	17	10	7
Acute Allergic Dermatitis	(10)	(6)	(4)
Chronic Urticaria	(1)		(1)
Allergic Conjunctivitis	(1)	(1)	
Allergic Tracheitis	(4)	(2)	(2)
Acute Labrinthitis	(1)	(1)	
Total	140	77	63

All patients had been given a meticulous allergic survey, including a history, physical examination, intradermal skin testing, and needed laboratory procedures. Those chosen for the study were: (1) patients who responded poorly to a regimen of supposedly adequate hyposensitization combined with

* The triamcinolone acetonide used here was the Squibb brand, tradenamed KENALOG I. M.®

† Deceased

environmental and dietary changes and conventional supportive measures and (2) patients, particularly those with pollenosis, who were seen for the first time after the pollen season was well underway and were not relieved at all by coseasonal hyposensitization and the usual symptomatic medications (antihistamines, nasal decongestants and, in a few instances, orally administered steroids). Hyposensitization schedules were continued for all who were receiving treatment when the triamcinolone acetonide was started, but supportive measures, including the oral administration of antihistamines, were discontinued.

All patients were seen weekly. Subjective responses, elicited by careful questioning, were recorded and their objective responses were measured by conventional clinical methods.

and, in many cases, within 4 to 6 hours. Results of treatment with triamcinolone acetonide* were judged to be "excellent" when relief of symptoms was noted within 24 hours and persisted for more than two weeks without need for other medication. Results were considered to be only "fair" when more than 24 hours elapsed before relief of symptoms, when the duration of relief was less than two weeks, or when other medications had to be used to relieve the symptoms. Absence of relief of symptoms at all was judged a "failure."

Results

During the study period, the 140 patients with allergic disease received a total of 286 injections. Ninety-four patients received only one injection, 18 patients received two injections, 12 patients received three injections, and the 16 remaining patients each received more than three injections. A usual injection was 40 mg triamcinolone acetonide.* Two patients received 19 injections, each totalling 1,140 and 785 milligrams of triamcinolone acetonide, respectively.

Table II

Condition Treated	*Number of Cases*	*Results of Treatment* *Excellent*	*Fair*	*Failure*
Pollenosis	45	41 (91%)	4 (9%)	0 (0%)
Bronchial Asthma	44	38 (86%)	4 (9%)	2 (5%)
Allergic Rhinitis	34	25 (74%)	7 (21%)	2 (6%)
Miscellaneous	17	14 (82%)	2 (12%)	1 (6%)
Total	140	118 (84%)	17 (12%)	5 (4%)

Table III

DURATION OF EFFECT

Total Number of Injections	*0 to 2 Weeks*	*2 to 4 Weeks*	*4 or More Weeks*
286	12 (4%)	59 (21%)	** 215 (75%)

Triamcinolone acetonide,* as a 40 mg/ml aqueous suspension, was administered by deep intramuscular injection into the upper outer aspect of the gluteus muscle, through a 21-gauge needle. The usual dose was 40 milligrams, but in a few instances as little as 20 milligrams were given and in some others 60 or 80 mg were administered, usually as two or three doses. Intervals between injections were determined by the duration of clinical effects.

The effects of this medication, in almost every instance, were manifested within 24 hours

The results of therapy for the various allergic disorders are outlined in Table II. Of the 140 patients treated, 118 (84 per cent) had excellent results and 17 patients (12 per cent) had fair results. There were 5 failures (4 per cent). Of the 286 injections administered, 215 (75 per cent) had a duration of effect of at least four weeks, 59 (21 per cent) had a duration of effect of two to four weeks, and 12 (4 per cent) had a duration of effect of less than two weeks. (See Table III).

* KENALOG I. M. (Squibb)

** Some of the conditions were self-limiting in nature, making it difficult to assign a meaningful duration of effect.

Adverse effects were encountered in 15 of the patients treated (11 per cent). Six patients complained of a flushing of the face, particularly of the malar areas, occurring within hours of the injection and lasting 6 to 24 hours. In one of these patients there was an associated urticaria. Two developed a bitter, metallic taste that persisted for two weeks. Two patients had episodes of intermenstrual bleeding. One patient showed slight edema. A 79-year old woman with bronchial asthma and chronic pulmonary emphysema, who had received 785 milligrams over a two-year period after oral steroid therapy, developed osteoporosis and a subcutaneous area of fat necrosis at the site of injection. One man with clinical evidence of prostatic hypertrophy complained of increased frequency of micturition and increased difficulty in voiding for six hours after an injection. A 37-year old woman complained of increased facial hair and a loss of libido. One patient had a flare-up of symptoms related to an apparently silent peptic ulcer after a single injection of 40 milligrams.

Comment

The clinical study in allergic patients confirms that very favorable responses can be obtained in patients with allergic disorders when adequate doses of steroids are administered intramuscularly. The best results were obtained in patients with pollenosis, ninety-one per cent of these showed "excellent" results and none showed a treatment "failure" (Table II). Included among the 45 patients of this group were 18 (seen for the first time after the pollen season had begun), with very severe symptoms that were unrelieved by antihistamines. Sixteen of these 18 patients became asymptomatic within 24 hours of a single intramuscularly injected dose of triamcinolone acetonide* and remained asymptomatic for the duration of the pollen season. Results were equally striking in the treatment of the allergic dermatoses, particularly of the self-limited contact dermatitides, such as poison ivy.

The majority of patients received only one injection of 40 milligrams of triamcinolone acetonide.* Many in this group were kept asymptomatic for two to more than four weeks after the injection. The calcuated daily dose of triamcinolone acetonide* for each patient given this regimen was between one and three milligrams. This is considerably less than would be required with conventional oral triamcinolone treatment.

Injection deep into a large muscle mass with a long needle markedly reduced the incidence of atrophy of subcutaneous fat. There were no objections to this method of administration, nor was there any complaint of pain at the site of injection.

Repository therapy with triamcinolone acetonide* appears to have the following advantages:

(1) Rapid onset and a prolonged duration of action.

(2) Avoidance of dependency on steroids. No patient included in this study had withdrawal symptoms when administration of steroids ended.

Indeed, two patients treated with this injectable steroid were freed of their previous dependency on orally administered steroids.

(3) Minimal side effects. There were no instances of weight gain or stimulation of appetite.

(4) Exact control of therapy by the physician.

Repository administration of steroids appears to have the same disadvantages as does oral administration. The same precautions should be observed as with any patient in whom corticosteroid therapy is indicated. Therapy with corticosteroids should be reserved for those patients not responding to conventional treatment.

Summary

A total of 286 intramuscular injections of triamcinolone acetonide* suspension was

* KENALOG I. M. (Squibb)

given to 140 refractive, allergic patients with pollenosis, bronchial asthma, allergic rhinitis, and such miscellaneous conditions as sinusitis, nasal polyps, allergic dermatitis, and severe chronic urticaria.

The usual dose was 40 milligrams. Eighty-five per cent of the patients reported "excellent" results, 12 per cent reported "fair" results, and 3 per cent reported "failures." Relief of symptoms was noted within 24 hours and lasted two weeks to more than four weeks in 95 per cent of the treatments.

Corticosteroid side effects should be kept in mind and the same precautions observed as in patients on oral corticosteroid therapy.

Bibliography

1. Anderson, H. O.: *J. Kansas Med. Soc.* 61:561 (1960)

2. Baer, R. L. and Witten, V. H.: *The Yearbook of Dermatology and Syphilology,* Chicago, 1959, Year Book Publishers, p. 39.

3. Booth, B. H.: *Indiana State Med. Assoc.* 54:1635 (1961)

4. Hefley, B. F.; and four others: *Annals of Allergy.* 22:244 (1969)

5. Hollander, A.: *Antibiotic Med. & Clin. Therap.* 8:87 (1961)

6. James, A. P. R.: *Antibiotic Med. and Clin. Therap.* 7:495 (1960)

7. Lockie, L. M., *et al.: Geriatrics.* 15:696 (1960)

8. Miller, D. S.:*Clin. Med.* 8:1161 (1961)

9. Olansky, S. and McCormick, G. E.: *Current Therap. Res.* 5:319 (1963)

10. Scher, R. K.: *J. Am. Geriatrics Soc.* 12:328 (1964)

11. Schwartz, S.: *Current Therap. Res.* 5:431 (1963)

12. Sulzberger, M. M., *et al.: Dermatology; Diagnosis and Treatment,* 2nd ed. Chicago, 1961, Year Book Publishers. p. 111.

13. Zuckner, J.: *Ann. Rheumatic Diseases.* 70:274 (1961)

689 Foothill Road

Mumps Vaccine Reported Safe And Effective

Further evidence that a newly developed mumps vaccine may be safe and effective is reported in the *Journal* of the American Medical Association (September 18, 1967). This has been under development for some time. The vaccine is not yet available to the public, but this latest, limited test of one vaccine strain is a step in establishing its safety and effectiveness. The vaccine had been tested earlier on children, this was its first test on adults.

Ninety-five adults were tested, but 75 of these were found to have varying amounts of mumps antibodies, even though they could not remember contracting the disease. Tests on these 75, however, indicated their antibody levels were increased.

Mumps is not as contagious as, for instance, measles (95 per cent of adults have had measles), so more people reach adulthood without contracting the disease. And of course, mumps can be dangerous, particularly for adult men. The disease can damage the brain, pancreas, testicles, or the eighth nerve.

This *Journal* report, by investigators at the Merck, Sharpe and Dohme Company laboratories and Merck Institute for Therapeutic Research, concerns a live-virus mumps vaccine called the Jeryl Lynn strain. There were no serious adverse reactions to the vaccine. Fever was "remarkably absent" in those whose blood tests had shown no evidence of existing mumps antibodies. "The vaccine provides a potentially useful tool for eliminating (sickness) time loss from mumps," said the report.

We ought to know more about psychotomimetic drugs, but not one has been found of any consistent medical or psychological use.

Neuropharmacology Of Psychotomimetic Drugs*

Henry B. Murphree, M.D./New Brunswick

Aldous Huxley once suggested that man was probably a pharmacologist before he was a farmer. That is, long before man actually cultivated crops, while he was still a hunter-gatherer, he knew that if he ate certain leaves, roots, berries, or mushrooms some peculiar effects would follow. Some of these became adjuncts to ritual practices long before the beginnings of history. These practices relate mainly to three areas of human activity: religion, warfare, and healing, all of which involve efforts to improve the world we live in.

Alcohol is employed to this day in Jewish and Christian religious rites. Mushrooms have been used in religious activities from Siberia to Arizona. The one great system of belief in which religion and warfare were combined, Islam, has seen the use of hemp: the legendary Old Man of the Mountain gave his warriors hashish, whence comes our word assassin. The Royal Navy of Great Britain has had its ration of grog for centuries. Tales are told of the Viking berserkers who prepared themselves for battle by eating mushrooms.

Medicines were used in the past mainly as adjuncts to thaumaturgy, healing by magic. Often the healer, rather than the patient received the medicine. After this had put him into some suitably transformed mental state, he could perform whatever ritual was needed to drive out the evil spirits, invoke the good ones, and so on. Eventually it became clear that better results were likely if the medicine were given to the patient. But only very recently in the span of history has scientific method been employed to winnow out useful medications from dross. Even today, much dross is still found, and much of the thinking about drugs tends to be magical. Patients insist on "a shot of penicillin" for a cold, even though that is not only useless but dangerous, because everyone knows that penicillin is a "miracle" drug. And many physicians yield to this. The superstitious and fallacious use of drugs is very much with us at present, and is perhaps at maximum with psychotomimetic drugs.

The oldest drug substances with prominent mental effects include alcohol, opium, hemp, and assorted mushrooms. People often prefer not to think of alcohol as a drug, although it is one, because its use is widely tolerated in our culture and even virtually mandatory in that ubiquitous tribal rite, the cocktail party. Mushrooms have not gained widespread popularity because most of them cause distressing side effects. The consensus of normal volunteers given mescaline in our laboratory some years ago, after several hours of nausea and vomiting, was that we should give it back to the Indians. Opium is not useful as an adjunct to anything because it rapidly displaces all other interests. Opium users care nothing for religion, warfare, their state of health, or anything else except opium. Hence, opium has never been incorporated into any of these practices.

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*Read before the Section on Psychiatry and Neurology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1968. This paper is from the Department of Psychiatry and the Center of Alcohol Studies at Rutgers University where Dr. Murphree is Associate Professor.

Hemp

So let us begin with hemp which has been used for its psychotropic effects for many centuries and has recently become a fulminating psychosocial problem in our present culture. The plant, *Cannabis indica* or *Cannabis sativa,* is the same one that supplies fiber for rope. It is widely distributed in temperate zones. The flowering top of the female plant is rich in a sticky resin which contains the active principles, a group of complex alcohols called cannabinols and tetrahydrocannabinols. Many different preparations are made and many different names are applied: bhang, charas, kif, ganga, marijuana, Mary Jane, tea, pot, grass, and so on. Hemp preparations from different sources vary greatly in the amounts of active principles present. None seems to be truly hallucinogenic: sensory distortions and illusions occur, but not actual hallucinations. Other mental effects include marked impairment of abstract thinking and attention span. Associated with the latter are altered time sense, and impairment of concentration. Mood changes are frequent, and although euphoria is more commonly described, intense dysphoric reactions also occur. With larger doses, speech becomes slurred, and marked incoordination with staggering gait appears. Peripheral vasodilatation is prominent, manifested by marked conjunctival reddening and some tendency toward orthostatic hypotension. However, as commonly encountered in this country, marijuana doses are too small to have these more pronounced effects. This is because of the relatively low grade of material plus the inefficient administration by smoking in which much of the active principles are probably destroyed by heat. In fact, much of what happens in users at "pot parties" is probably a placebo effect plus hyperventilation from the overbreathing and use of the Valsalva maneuver which are part of the ritual.

The active principles are of interest, because they contain no nitrogen atom. They are complex alcohols with the same kinds of pharmacologic actions as more familiar alcohols. If the hydroxyl group is removed, the intact remainder of the molecule is inert. The effects of hemp are similar to the effects of drinking impure alcoholic beverages. The "red eye" whiskey of saloon days caused the same conjunctival vascular engorgement, probably due to higher alcohols which were not fractionally removed as nowadays but were carried over into the finished product by less precise distillation methods.

Thus it cannot be said that "pot is better than booze." Pot *is* booze, but a kind more likely to cause trouble. A really effective dose is much longer acting (in the range of eighteen hours). The dose cannot be determined accurately, and, therefore, effects cannot be predicted; and one of the very likely side effects is jail.

Anticholinergics

Many other plants have potent psychotropic actions, which have not gained such widespread currency. Among these are plants containing alkaloids with belladonna-like action (atropine-scopolamine). Notable in this country is the Jimson (Jamestown) weed, *Datura stramonium.* Cases of poisoning with Jimson weed are seen occasionally. Sporadic instances of self-induced stramonium intoxication have been reported. Many synthetic drugs are close relatives of atropine chemically and pharmacologically. The best-known of these is "Ditran" which has been studied for possible therapeutic effect.

These drugs have not gained any popularity among illicit users. Possibly this is because of several adverse characteristics: these drugs are long-acting; they produce amnesia, so that little is remembered of the episode; they cause marked physical discomfort. They can be dangerous because they disturb temperature regulation, so that in a warm environment, pyrexia occurs. Along with this, the person is hyperkinetic and will often refuse food or water. Thus, serious dehydration and exhaustion can occur.

The mental effects are those of a toxic delirium. Attention span and concentration are

markedly shortened. The person tends to ignore his environment, to be nonresponsive, and to be preoccupied with his hallucinations and delusions which are quite vivid at the time but are recalled only with difficulty later. Mood changes are not prominent.

The clinical picture with all of these drugs is similar to that of atropine poisoning. Treatment involves the use of a cholinomimetic or cholinesterase inhibitor drug, such as physostigmine or tetrahydroaminoacridine. However, the management is tricky and is best left, if possible, to one who has some previous experience with it.

Phenethylamines

The phenethylamines comprise a large group of compounds chemically and pharmacologically related to the adrenergic neurohumor-hormone substances, norepinephrine and epinephrine. Some of these, such as the amphetamines act only as stimulants in ordinary doses. Excessive doses become psychotomimetic, however, and one of this group, methamphetamine (Methedrine,® desoxyephedrine, Desoxyn,® "Speed" and so on) is often deliberately taken in overdosage for this effect.

Other members of the group are used, not as stimulants but as psychotomimetics, although they are not necessarily more potent than amphetamines in this respect. Such is the case with mescaline, the active alkaloid in peyote. Peyote "buttons," the cut off tops of the small "dumpling" cactus, *Lophophora williamsii,* were first studied scientifically by Lewin in the 1870's. The alkaloid, mescaline, was isolated by Heffter in 1896. In 1928, Küver suggested that this might be a useful tool for studying mental illness. If one could use the compound to produce a "model psychosis" in normal subjects, an understanding of the changes that occurred might yield insight into the nature of "real" psychosis. The effects of mescaline do not mimic real psychosis very accurately, and the drug is not a very potent or reliable one. Its most consistent effect is nausea and vomiting. The effects are generally like those of LSD.

Other compounds are closely related chemically and pharmacologically to mescaline. One which has gained some notice lately is an old synthetic compound DOM, also a substituted Beta-phenethylamine. This has been identified as the compound called STP. Some of the descriptions of STP effects sound much more like the anticholinergics than the Beta-phenethylamines. This reminds us that more than one compound may be circulated illicitly under the same name.

Another compound related to this group is myristicin, the active principle in nutmeg. This has an olefinic carbon in place of the amine nitrogen. This causes some differences in pharmacologic action. In some ways the effects are atropine-like, but the pupils are constricted. This evidently results from general constriction of smooth muscles, much like that due to opiates, because constipation and difficulty with urination are also uniform effects. There is no antidote for myristicin. Abuse of this drug has a built-in penalty in the form of a severe "hangover" characterized mainly by severe aching all over the body.

Tryptamine Derivatives

Several substituted tryptamines are psychotomimetic and some have found their way into illicit use. Examples are: N-dimethyltryptamine (DMT); N-diethyltryptamine (DET); alphamethyltryptamine; N-dimethyl-4-hydroxytryptamine (psilocin); and phosphorly, N-dimethyl-4-hydroxytryptamine (psilocybin). These are similar to each other and to LSD, the most famous member of the group. They differ in milligram potency and duration of action. For the sake of brevity, only LSD will be discussed in detail.

N-diethyllysergamide (lysergic acid diethylamide, Lysergsäure diäthylamid, *d*-LSD-25, LSD) was first synthesized by Hoffman in 1938. Its peculiar properties were not discovered until 1943, however. In 1947, the Swiss psychiatrist, Stoll, published the first report of this drug which was then by far the most potent ever known.

Initially there were two questions about LSD: Did it have any diagnostic value? And did it have any therapeutic value? Stoll had concluded that the effect was mainly toxic and not clearly related to the personality of the subject. Subsequent investigations have supported this. The second question has taken longer to answer. At present, the consensus seems to be that if LSD has any therapeutic value at all, this is only in a small number of selected cases.

The production of model psychosis was suggested by Küver to try to learn more about the nature of psychosis in general. This has not been productive of any new understanding.

There has been a search for antidotes against LSD. Such compounds might have promise as therapeutic agents against some kinds of mental illness. This has some cogency, since chlorpromazine is the most effective antidote against LSD so far known and is a useful psychotherapeutic drug.

We are concerned with the study of biogenic amines in the brain. In the early 1950's, LSD was found to antagonize the actions of 5-hydroxytryptamine (5-HT, serotonin), an amine normally present in the body. The postulate made independently by Wooley and Gaddum was, in Gaddum's words, "It may be that the serotonin in our brains keeps us sane." Shortly thereafter, however, reserpine was found to deplete the brain of 5-HT, even while ameliorating psychotic symptoms. The roles of biogenic amines in the brain in mental health and illness continue to be unsolved, although interesting possibilities are being explored.

In 1957, a new shadow appeared with the introduction of the word "psychedelic," meaning "mind manifesting." The idea is that LSD somehow enables the taker to gain amazing insights not only about himself but also about all of reality, and of unreality, indeed of all of the universe it would seem. The proponents of this have taken LSD out of the world of science into a milieu of pseudometaphysical charlatanism and social disrepute. As a result little serious work has been done with the drug since about 1962.

"Psychedelic" is a siren word; it has an alluring sound to some people and thereby gets them into misfortune. Actually the experience which the mind manifesters are describing is not new or unique to LSD. It has been known for many years and can be brought about in many ways. William James has given a very clear description of the effect as a result of religious conversion. Mystics and witch doctors for centuries have used fasting, flagellation, exhaustion, and the like to help themselves achieve the effect. It is most easily produced by some variety of noxious effect on the brain; fever will do, but drugs are easier. Oliver Wendell Holmes understood very well this phenomenon to which he gave the name "Great Truth" experience. He came to know it in the course of experimentation with general anesthesia. He also recognized well that the effect is specious. The Great Truth in the grey light of the morning after is usually trite of silly if not downright incomprehensible. No convincing evidence has been presented to show that creativity, originality, or any other higher faculty is improved rather than impaired by a drug, the effect of which, by all objective criteria, is to disrupt the functioning of the nervous system.

The physical effects of LSD are prominent although often overlooked or ignored. The most consistent effects, occurring with the smallest doses, appearing soonest after dosage, and lasting longest, are on the pupil of the eye. Mydriasis is marked, and is not due to cycloplegia. Pupils are fairly often unequal, and hippus (sometimes in phase with the respiratory cycle) is common. This is not clearly related to subjective sensations of changes in lighting. Waves of piloerection are usual, as is hyperreflexia. The latter often progresses to spontaneous clonus. Subjects often complain of feelings of tightness in the jaw, but objective trimus is not demonstrable, although masseter hyperreflexia is. Nausea and vomiting are common. Sub-

jects often seem to feel unusually hungry but then to eat little. Cardiovascular effects are not impressive, and are probably only secondary to the general state of excitation caused by the drug.

Recently chomosomal breaks in leukocytes have been reported in both *in vitro* and *in vivo* studies following exposure to LSD. There have been suggestions that use of the drug may therefore lead to abnormal infants, assuming germ cells might be affected like the leukocytes. At this writing, the evidence is inconclusive and conflicting. However, the dubious benefits of the drug would hardly seem worth the risk that this possibility is true.

Acute subjective effects are indeed sufficiently bizarre to merit the term "psychotomimetic." They do not mimic schizophrenia very closely, however, but are more similar to a toxic psychosis as first suggested by Stoll. Feelings of unreality are followed by depersonalization and marked disturbances of body image. Visual illusions and hallucinations, especially involving geometric patterns and vivid moving streams of color are common. These are reminiscent of effects experienced by patients with high fever, and may come about through the same mechanism, since LSD can cause increases in body temperature in some species. True auditory hallucinations are rare although distortions and illusions are common. This is in contrast to schizophrenia. Disturbances of affect almost always occur. Although enthusiasts stress the euphoric effect, dysphoria is at least as common, and quite typically the subject will have alternations of mood. Paranoia is also common, often closely related to the disturbances in body image and dysphoric feelings of terror. This is not clearly related to the everyday personality of the subject. Suicide may eventuate, but is rare. Death can occur in a more indirect way, however, as when the subject thinks he can fly and steps out of a high window. This is one example of the marked impairment of judgment which the drug causes.

A danger with this drug is that the direction the effects will take cannot be predicted with any confidence. Even an accustomed subject may unexpectedly have a very adverse experience. Hence the terms "bad trip" and "down trip." The effects can be mitigated, however. One way is to keep up a high level of sensory input. The effects are maximal in a low stimulus environment. More effective is chlorpromazine which is the best antidote available.

The mechanism of action seems to be gross overstimulation of the central nervous system. This would explain the overactivity of the autonomic nervous system and spinal reflexes. Sleep is impossible for many hours after a dose, and LSD is analeptic against pentobarbital. The EEG effects of LSD are like those of amphetamine but more profound and much longer lasting. Here again the effectiveness of chlorpromazine against LSD fits in, because it and amphetamine are antagonistic to each other.

Carefully selected normal volunteers given the drug under carefully controlled laboratory conditions exhibit prolonged adverse effects only very rarely. One survey of reports involving 1648 administrations under such conditions turned up only 2 instances. These involved recurrences of the drug experience for periods up to one week.

In considering adverse effects when the drug is taken illicitly, two points must be kept in mind: first, drug taking of this sort is symptomatic, and may be just one more set of bumps in the road the person was already traveling and would continue on even without the drug.

Second, drugs obtained illicitly are not reliable. The making of LSD is not as simple as it has sometimes been depicted, so that oftentimes by-products of unknown toxicity may well be present. The illicit producer cannot be depended on to bother himself with purification. The second point may also have some relevance to the problem of whether such drug taking is likely

to result in malformed infants. One remembers here that ergot alkaloids have prominent effects on blood circulation and uterine smooth muscle.

Conclusion

When all of the medical facts about these drugs are considered, the reasonable conclusion would seem to be that there is no impressive reason in favor of exposing oneself to the many demonstrable adverse effects and possibly to others not yet so clear. Yet some people continue, often with an almost exhibitionistic obstinacy. One can only infer that they do so for reasons not altogether related to the drug effects alone. Instead, the action seems to be symbolic if not symptomatic. It should be remembered that we live in a drug-oriented culture. The idea is still very prevalent that somehow by swallowing something we can make things better. Commerical fortunes are made from this: 60,000,000 pounds of aspirin per year, 600,000 pounds of barbiturates per year, and so on. Most people are guided in their drug taking by what is socially acceptable, and by superstition, rather than by any objective criteria. Generally, if it's on television, it's o.k. Yet, alcohol and barbiturates unquestionably account for more misery and death than all other drugs combined. Many of the people who take more disreputable drugs are in part more or less consciously reacting against this irrational social bias. Yet they are nonetheless making the same mistake, which is very ancient. Despite history, the idea that drugs with strong mental effects can improve the world is wrong. Penicillin can do wonders, but not through magic, and it has no power to solve the perpetual abrasive problems of human beings trying to live with each other and with themselves. A real reshaping of the world we live in will have to come from some other source than a bottle.

Rutgers University

You and Automotive Safety

The AMA Committee on Medical Aspects of Automotive Safety, in cooperation with the United States Public Health Service, urges all physicians to help cut the huge toll of death and injury to infants and children from automobile accidents by warning parents of the dangers of riding in a moving automobile without seat restraints.

Harold A. Fenner, M.D., AMA Committee chairman, points out that parents allow children to stand with their faces practically touching the automobile windshield. Children should *never* even be allowed to sit in a moving automobile without restraints. "Parents who ordinarily go to great extents to protect and care for their children here risk them unnecessarily to disfigurement, injury, and death," Dr. Fenner said. "Physicians, especially pediatricians," he said, "often have an unusual opportunity to reach parents with this information."

The U.S. Public Health Service advises the use of presently available equipment, but urges the automotive industry to develop improved restraints, including shoulder straps. The PHS seat belt campaign includes asking law enforcement officers and news media to include a report on seat belt usage in traffic accident stories, with the hope that publication of such information would further impress people with the crucial importance of wearing safety belts.

Anticipating, preventing, or managing a pulmonary embolus requires swift and decisive action. But how? Here is how.

Pulmonary Embolism: An Evaluation

William A. Dwyer, Jr., M.D./Paterson

By definition, an embolus is all or part of a blood clot formed in one part of the circulatory system which has broken off and been transported to another location. The emboli which lodge in the pulmonary arterial circulation arise almost exclusively from thrombi in the pelvic or femoral veins. Depending on the size of the clot, the amount of pulmonary surface involved, and whether single or multiple, the patient's stable state can be unaffected or completely disrupted, and this disruption can be either rapid or insidious.

Six reasons for the formation of thrombi in these locations are: (1) infections of the veins proper (thrombophlebitis); (2) pressure on the veins from pregnancy or tumors; (3) immobilization of either the limb or the patient due to operation, traction apparatus, and so on; (4) any disease state causing hypercoagulability of the blood, (e.g., polycythemia vera); (5) any disease state which causes stasis or stagnation of the blood stream, (e.g., hypotensive shock); and (6) trauma to the vessels of a limb (particularly blunt injury). There are certainly other causes, too.

Current Concepts in Therapy

The size of the embolus and the amount of lung parenchyma affected determine the amount of derangement of the patient's stable state that occurs. From the degree of this derangement, it is possible to derive a useful set of therapeutic classifications:

1. Thromboemboli — Minor; less than 25 per cent occlusion of lung tissue.

(a) Acute, segmental or subsegmental.

(b) Chronic Recurrent, subsegmental or segmental.

2. Thromboemboli — Intermediate; more than 25 per cent occlusion. These may be further classified as above.

The difference between 1 and 2 is the existence of pulmonary hypertension and the possible coexistence of hypotension or shock in the latter group.

3. Thromboemboli — Major; more than 45 per cent occlusion. These are acute, involving main or multiple lobar arteries.

This group shows little or no disturbance in peripheral blood pressure and no pulmonary hypertension.

4. Thromboemboli — Major; more than 45 per cent occlusion. This is usually acute—main or multiple lobar.

This group is in profound shock and in extremis.

5. Thromboemboli — Major; more than 45 per cent occlusion. This is chronic — main or multiple lobar.

This group has no disturbance of peripheral blood pressure, but does have pulmonary hypertension.

It will be noted that this classification ranges from the most minor to the most major of emboli and provides a functional as well as an anatomic basis for consideration.

The symptomatology of this disease is very variable. The classic picture is the sudden onset of pain in the chest followed by shortness of breath and hypotension. In actuality, there can be no pain, a pleuritic type of pain, pain at the base of the neck or in the upper abdomen, and even night cramps in the recumbent position. This can occur with or with-

out shortness of breath and with or without coma or syncope. Hemoptysis may occur as may a dry cough or hoarseness. The symptomatology may even be confined simply to a transient "strange sensation" or a "feeling of impending doom."

The signs associated with it are those related to the circulatory changes induced by the embolism:

Bradycardia followed by tachycardia (a function of low cardiac output) may occur.

"Cross of Traube" may be noted on the temperature — pulse record (a subnormal, decreasing temperature record crossed by a rising pulse rate over 100).

Neck vein distention may become obvious.

Air hunger may be present.

Narrow pulse pressure and hypotension may be present.

A rapidly enlarging liver may be noted (due to onset of chronic passive congestion).

Cyanosis may be noted.

Acute oliguria may occur as may also chronic renal insufficiency.

A variety of murmurs may be noted over the pulmonic valve area.

A protodiastolic gallop rhythm may sometimes be noted.

Occasionally, there may be alterations in breath sounds that are audible.

Pulmonary gas studies may be of some help in diagnosis, particularly the arterial-alveolar pCO_2 gradient. The usefulness of this test, however, would be confined to patients in the latter four groups and would be additionally altered by the existence of a pulmonary problem in the patient.

X-rays can be helpful in the establishment of the diagnosis. However, the routine chest plate is suggestively positive in less than 50 per cent of cases.

By contrast, pulmonary angiography provides a high degree of diagnostic accuracy[1] and is coming to be recognized as the most reliable entity available. Additionally, its use has been shown to be both simple (if necessary, it can be carried out with a single Robb-Steinberg 12-gauge needle with hand injection) and safe. (Steinberg[2] reports on 25 years of experience with this technic; University of Kentucky reports on 100 cases of embolus, 13 of which were in shock at the time of procedure and none of whom experienced any ill effect.) It too has some inherent error, however.

Electrocardiographic changes are sometimes helpful when serial tracings can be obtained. Also of some help are the enzyme tests (SGOT and LDH measurements.) The LDH value is usually elevated, and the SGOT is normal in pulmonary emboli, but the reverse is true in myocardial infarction.

Treatment of this condition, of course, begins with prevention. There are many things that can be done that help to prevent thrombosis:

(1) Ace® bandages to the legs which help to prevent venous stasis.

(2) The use of Neo-Polycin® ointment on cutdown and catheter sites to prevent infection and subsequent thrombosis.[3]

(3) Small amounts of Heparin in venous catheters for the same purpose.

(4) Encouragement of patient motion of toes, fingers, knees, and so on, while at bed rest.

(5) Careful checking of immobilizing dressings.

(6) Use of anticoagulants as a routine measure postoperatively in any patient who will be immobilized for a prolonged period of time.

(7) The use of a guide as an aid in predicting those patients who would be embolus-prone.[4] Such a guide provides an indicator for increased clinical vigilance and in really high index patients another guidepost for the use of anticoagulants.

Even utilizing all of these measures, however, some patients are still bound to fall victim to this disease. Treatment *after* pulmonary embolus has occurred depends (in part) on the type and kind of involvement. This can be separated into a graduated scale of physiologic disorder and therapy rendered in orderly fashion according to this scale.

At the minor end of this scale is the small infarct which causes no disturbance. This is picked up as the result of clinical suspicion

coupled with x-ray, enzyme, and electrocardiographic findings. The only therapy required is the prompt institution of anticoagulation with Heparin given intravenously, followed by the routine subcutaneous administration of the same drug over a period of 14 to 21 days and subsequently followed by Coumadin® for a period of six weeks. The usual contraindications for the use of these agents apply, and where applicable may constitute an indication for vena cava ligation.

The acute onset of greater than 25 per cent segmental or subsegmental occlusion accompanied by hypotension calls for more vigorous initial measures — specifically the addition of both intravenous morphine and aminophylline, as well as nasal oxygen to the previously described heparinization. Additionally, these patients after the initial episode are confined to bed rest. Repeated episodes of embolization in either of the above two groups is an absolute indication for vena cava ligation provided the heparinization is adequate.

Additional indications for vena cava ligation now being seriously considered include the following: (1) shock, unconsciousness, convulsions, right heart failure, or major electrocardiographic changes in association with the embolic episode; (2) chronic recurrent pulmonary emboli in which pulmonary hypertension and low cardiac indices are present at rest or exercise; (3) where the peripheral venous pulmonary angiogram indicates greater than 25 per cent occlusion of the pulmonary vasculature or where the pulmonary angiogram indirectly indicates right heart failure; (4) where the central venous pressure is greater than 15 centimeters of water; (5) where the arterial-alveolar gradient of carbon dioxide is greater than 6 millimeters of mercury.

The last group are the occlusions greater than 45 per cent. These will need the previously described regimen for the more seriously affected "minor embolus" group. Many, if they are to be salvaged, will need a partial cardiopulmonary bypass and a pulmonary embolectomy.

The criteria for the latter are (1) persistent shock with greater than 45 per cent occlusion of the main or multiple lobar pulmonary vasculature as determined by pneumoangiogram either with or without an antecedent vena cava ligation; (2) failure to achieve systemic stabilization despite vigorous medical efforts. Both criteria must be met.

Certain minima are necessary for the treatment of pulmonary emboli. Foremost, is a reliable pneumoangiographic capability to ensure diagnostic accuracy in most cases. Second is the necessity to institute a cardiopulmonary bypass technic. With the introduction of the disposable oxygenator and pump priming with glucose solutions, the cost of this is within the reach of most community hospitals, and certainly should be within the reach of all regional hospitals.

Nothing less than such capability is satisfactory treatment for *all* cases of pulmonary embolism. This capability coupled with a vigorous prevention program should be the answer to this very vexing clinical problem.

Bibliography

1. Hildner, F. J. and Ormond, R. S.: *JAMA,* 202:567 (November 13, 1967)

2. Steinberg, I. and Stein, H. L.: *Am. Journal of Roentgenology,* 92:893 (October, 1964)

3. Moran, J. M., Atwood, R. P., and Rowe, M. I.: *New England J Med,* 272:554 (March 18, 1965)

4. Breneman, J. C.: *JAMA,* 193:576 (August 16, 1965)

5. Beall, A. C., Jr., Cooley, D. A., and De Bakey, M. E.: *Diseases of The Chest,* 47:383 (April, 1965)

6. Madsen, C. M. and Buhl, J.: *Acta Chir. Scandin,* 128:721 (December, 1964)

7. University of Kentucky Symposium on Pulmonary Thromboembolism, 1967.

8. Frater, R. W. M., Schneider, I. J., Kaplan, N., and Tirschwell, P.; *JAMA,* 196:11 (April 4, 1966)

112 Park Avenue

Here is a safe and simple way of relieving postpuncture headache, in Dr. Ainslie's experience.

Simple Relief Of Post Spinal Headache

William H. Ainslie, M.D./Metuchen

Spinal headache is a frontal or occipital headache, frequently associated with a stiff neck, that follows administration of a spinal puncture.[1] It is either accentuated or brought on by the erect position and usually leaves soon after the patient lies flat. The headache is part of the syndrome of decreased intracranial pressure.[9]

About eleven per cent of all spinal punctures are followed by headache. Spinal punctures with vaginal deliveries[3] produce about twenty-two per cent of the post spinal headaches. This higher incidence is attributed to changes in blood volume and intra-abdominal pressure. Older women seem more prone to this annoying complication.[2]

Only about one in ten cases starts on the day of the spinal tap. About 30 per cent start on the first day and another 21 per cent on the second day.[3] Thirteen per cent start on the third day following the administration of a spinal injection.[1]

Without treatment, 24 per cent of these headaches only last one to two days, while another 29 per cent last three to four days and about 19 per cent last five to seven days. Some, however, will last up to a year.

Cerebral spinal fluid may leak from the site of entry into the dura following lumbar puncture.[5] Vaso-dilation[7] and stimulation of pain sensitive blood vessels within the cranium follows the loss of cerebral spinal fluid.[9] There is no correlation between the incidence of headache[9] and the degree of decrease of cerebral spinal fluid pressure.[6]

Use of a small bore spinal needle will reduce the incidence of post spinal headache: thus the incidence varies[14] from 9 per cent (with a 22 gauge needle) to 18 per cent (with a 16 gauge needle). Body hydration[5] is important as proper hydration relates to the secretion of cerebral spinal fluid and maintenance of the cerebral spinal fluid pressure.[9] Special positions of the patient and keeping the patient prone for 24 hours after spinal are of no special benefit.[6]

Treatment

The use of extra abdominal pressure to relieve spinal headache was demonstrated to the author many years ago and he does not claim this as an original contribution. Search of the literature, however, has disclosed only one scant reference[1] to the use of extrinsic abdominal pressure. One purpose of this paper is to give wider publicity to an effective and simple treatment. According to Vandom,[9] an increase in intra-abdominal pressure raises the peridural venous pressure and thus relieves the headache. This method can be used in all cases except those with upper abdominal surgery with an incision in the epigastrium. The author has yet to see one case fail when the pressure is applied properly.

When the patient first complains of a headache that intensifies or appears on sitting or standing, and is not relieved by simple analgesics, the patient is queried as to whether pre-operative headache was present or whether there is a history of similar head-

aches. If the answers are negative, the patient is asked to stand. One hand is placed in the small of the back as a brace, and the other, in the form of a fist is pressed gently but firmly into the episgastric area of the abdomen, just below the xyphoid process. The pressure of the fist is increased slowly but steadily until the patient spontaneously notes a reduction or relief of the headache. The patients often describe their relief as a "band being lifted from the head." The fist is then removed. Purpose of this step is to prove that the headache *can* be treated. I have yet to see this maneuver fail in a true spinal headache. A many tailed abdominal binder is now placed around the body and pinned with the upper edge on the level of the xyphoid process. The patient is then asked to stand and small towels are folded and stuffed into the inverted V below the xyphoid between the skin and the binder. The stuffing is continued until the headache is gone. An orange wrapped in a wash cloth does an excellent job of pressure. Once relief is obtained, the patient is instructed to remove the packing material from under the binder when he lies down but to replace it whenever he stands, walks, or sits. The patient can replace this himself. Usually, with 24 to 36 hours of this binder with counter pressure, the treatment can be discontinued without reappearance of the headache. The patient should be told that almost complete relief should be achieved with each stuffing. This stuffing can be done only while standing. Be sure that the stuffing is removed when the patient is lying down in order that normal circulation and digestion be allowed.

Conclusion

A simple effective measure for the relief of post spinal headache by upper gastric pressure has been presented.

Bibliography

1. Hale, D. E.: *Anaesthesiology,* Second Edition. Philadelphia, 1963, F. A. Davis Company.

2. Dripps, R. A.; Echenhoff, J. E.; Vandom, L. D.: *Introduction to Anaesthesia.* W. B. Saunders Co., 1961, Philadelphia.

3. Dripps, R. A.; Echenhoff, J. E.; Vandom, L. D.: *Introduction to Anaesthesia,* Ed. 2. W. B. Saunders Co., 1961, Philadelphia.

4. Vandom, L. D.; Dripps, R. A.: *J.A.M.A.* 161:586 (1956)

5. Rice, G. G.; Dobbs, C. H.: *Anaesthesiology,* 11:17 (1950)

6. Green, N. M.: *Physiology of Spinal Anaesthesia.* Williams and Wilkins Company, 1958, Baltimore.

7. Reitman, H.: *Acta Radiology,* 22:762 (1941)

8. Vandom, L. D.; Dripps, R. A.: *J.A.M.A.* 161:586 (1956)

9. Vandom, L. D.; Dripps, R. A.: *J.A.M.A.* 161:586 (1956)

10. Franksson, C.; Gordh, T.: *Acta Chir. Scandinav.* 94:443 (1946)

I am indebted to Mrs. Alice I. Bernstein, Medical Staff Librarian at Perth Amboy General Hospital, for her cooperation in preparing this paper.

73 Amboy Avenue

Is Color Only Skin Deep?

"Yes" says the AMA's Committee on Cutaneous Medicine, which has just released a brochure called "Color Is Only Skin Deep." This publication, says the AMA, will dispel many of the mysterious hints and superstitions surrounding the subject of skin pigmentation.

Single copies of this brochure, written by Dr. S. William Becker of the Department of Dermatology of the University of Illinois, will be supplied by the Committee on Cutaneous Medicine, American Medical Association, 535 North Dearborn Street, Chicago.

Fear of malpractice litigation is, to some extent, contaminating doctor-patient relationships, according to this survey by Dr. Guthorn.

Toward A Defensive Stance In Medical Practice

Peter J. Guthorn, M.D./Neptune City

In the past few years doctors have been ordering a larger number of consultations, x-ray examinations, and other laboratory procedures than formerly, or than would usually be considered necessary. In discussing this with staff members, the trend was noted to have its origin in the increase of unjustified malpractice claims. Discussion with administrative and nursing personnel confirmed this impression.

The concept of "defensive driving" has gained wide recognition and support in diminishing automobile accidents. In medicine a set of somewhat similar circumstances points to "defensive medicine." Unfortunately, the by-product of the latter may be more expensive and less satisfactory care for the ordinary patient.

To evaluate this a questionnaire was distributed to the members of the staff of the Jersey Shore Medical Center. The following is a copy of the questionnaire.

1. Do you think the increase in malpractice claims has influenced the attitude of the doctor toward his patient?

2. Several theories have been advanced to account for the increase in malpractice claims. Indicate which you consider most important. If more than one, write the numeral "1" for the most important, "2" for the second, and so forth.

(a) Atrophy of the traditional doctor-patient relationship
(b) Growth of the "anything for a buck" philosophy
(c) Activities of the claimants' attorneys
(d) Public displeasure because of unavailability of many doctors on vacation, days off, etc.
(e) Unfavorable newspaper and magazine publicity
(f) Better medical knowledge on the part of the public
(g) Knowledge that most physicians are well insured

3. Do you request more consultation services than formerly to protect yourself against possible malpractice claims?

4. Do you find yourself ordering more x-ray and laboratory tests than are really necessary just to protect yourself from possible malpractice claims?

5. Does concern about hospital litigation cause you to shy away from rendering emergency service to people you don't know?

6. Do you feel the pinch of rising malpractice insurance premiums?

7. In the past ten years has any patient or ex-patient hinted at, or actually filed, a malpractice claim against you? In the past five years? In the past year?

8. Have you increased your limits of malpractice insurance in the last ten years? Last five years?

9. Do you place more emphasis on the type of consent for treatment than you did formerly?

10. Have you become increasingly cautious in discussing diagnosis, treatment, and prognosis with patients or families?

11. Do you avoid discussion of a previous doctor's treatment of your present patient?

12. Do you now pay more attention to nurses' notes on the hospital chart?

13. Do you now tend to make general, more evasive progress notes on the hospital chart and in describing operative procedures?

14. Do you know anyone who was discouraged from entering medical school or entering medical or surgical practice as a result of increasing malpractice suits?

The questionnaire was sent to 139 men. The fertility of the ground was obvious in the rapid response, 57 being returned within the first ten days and a total of 74 replying at the end of three weeks. The salient points are, that 67 men felt that increase in malpractice claims had influenced the attitude of the doctor toward his patient; 46 men requested more consultation services than formerly to

protect themselves against possible malpractice while 22 did not. Likewise 52 men ordered more x-rays and laboratory procedures than were previously considered necessary while 14 did not.

Physicians attributed this increase in malpractice claims *first* to the activities of the claimants' attorneys, *second* to the growth of the "anything for a buck" philosophy and *third* to the atrophy of the traditional doctor-patient relationship. The first two were extremely close.

Additional comments reflect some further aspects of the doctor's attitude. "Ethics of law practice require critical review" was repeated four times in that, or similar wording. Three replied that they "would not have their children become doctors under any circumstances." "Care can be pre-occupied by a feeling of distrust for the patient," "I am more concerned in avoiding trouble than in treating disease," "In addition to combating disease, the spector of the hungry plaintiff's attorney loomed out of proportion," "My approach is first to outwit any attempt to sue me for malpractice rather than to treat the patient's disease," indicated an additional aspect of the doctor's attitude. These were included in seven instances. One philosophical physician was of the opinion that "they are a symptom of the moral decay of our times." The reaction was not entirely in one direction because one man "thought he was practicing better medicine" and another that "the increase in suits has made doctors practice better medicine."

This questionnaire can be considered only as a preliminary investigation, but does indicate a substantial change in the attitude of the doctor toward his patient because of the unjustified malpractice claims.

The author acknowledges suggestions and assistance from Mr. Ernest Kovats and from Dr. Henry A. Davidson.

2100 Corlies Avenue

Bone Scan vs. X-Ray in Detecting Metastasis

In a talk at the AMA session in Atlantic City last June, Dr. David M. Sklaroff of the Einstein Medical Center, Philadelphia, suggested that the bone-scanning technic was the most sensitive available method of detecting metastatic malignancies in bone. This uses radioactive strontium-85, which follows the metabolic pathway of calcium and comes to rest in bone tissue much as iodine is attracted by the thyroid. Developed at nuclear medicine centers, scanning technics are now moving from experimental to clinical use. Scintillation scanners, a tool of the nuclear age, detect the gamma radiation emitted by the radioactive isotope after its incorporation into bone. Where tumor growth in the bone is active, radiation "hot spots" are readily detected, even at early stages. By contrast, tumor growth must cause significant decalcification of bone before the lesions are visible on X-ray.

Dr. Sklaroff reported initial results of a bone-scanning survey of women with stage II breast cancer. This study was undertaken to discover the reason for the low survival rate of stage II patients after radical mastectomy. In scanning patients with stage II breast cancer *at the time of surgery,* the investigators found that 17 per cent had bone lesions which were not visible on X-ray. "This," said Dr Sklaroff, "has led us to believe that these changes are most certain to be metastatic cancer and would account for the lack of improvement in this group of patients."

Urethral caruncles are nearly always benign. Here a carcinoma of a caruncle occurred in a patient who also had a carcinoma of the cervix. The authors' search of the literature has revealed only two other cases of this association.

Carcinoma Of The Cervix And Of A Urethral Caruncle*

Thomas K. Rathmell, M.D.
and
John D. Preece, M.D./Trenton

We here report a patient of major interest, a 39-year old woman who presented herself with a chief complaint of burning on urination for a period of three months.

The patient had never become pregnant and was first seen in 1958 for sterility. Rubin test was negative. Salpingogram revealed complete obstruction of the right tube and a partly filled left tube with dilatation. There was no contrast medium in the peritoneal cavity. The following year a left salpingostomy was done in an attempt to restore her fertility. A portion of the tube was removed. Pathologic studies showed endometriosis and salpingitis isthmica nodosa. Seven months later, a laparotomy was needed for a right tubal pregnancy. At that time, a right salpingectomy was done.

The patient was seen again in 1961, at which time forms were completed for the adoption of a baby. Then she was not seen by us for the next seven years. She then presented herself with the complaint of recurrent burning on urination for the past three months. Pelvic examination revealed a polypoid growth of the urethral mucosa without ulceration. The cervix was healthy in appearance and showed an intact mucosa. The uterus was of average size, and in an anterior position. The adnexa were not palpable. The inguinal glands were not involved. The patient would not tolerate a rectal examination. Papanicolaou smear of the cervix and vaginal pool was reported as a grade III. Because of this, the patient was advised to have a cervical biopsy and diagnostic curettage.

This procedure was performed in 1968. The cervix was biopsied and cauterized for hemostasis. The polypoid growth of the urethral meatus was excised and its base was cauterized. Study of the excised tissues revealed that the patient had a carcinoma of the cervix; in addition, a carcinoma of the urethral caruncle. (Figures 1 and 2)

The patient was later cystoscoped by Dr. Paul Parker to exclude any tumor of the bladder. At this time, there was no evidence of tumor of the urethra. The patient was subsequently admitted to Jefferson Hospital, under the care of Dr. George Hahn, where she had a radical hysterectomy with excision of the parametrial, paravaginal, paracervical tissues and upper vagina, with a dissection of the bilateral iliac nodes and a left salpingo-oophorectomy, right oophorectomy and closure of the cul-de-sac. The patient is to return for radium therapy of the urethra.

The field of oncology is replete with multiple tumors in the same individual; however, we have not previously had an opportunity to observe a patient with a combination of squamous cell carcinoma of the cervix and squamous cell carcinoma of a urethral caruncle. Finding these tumors in the same patient suggests that perhaps there is some basis for the concept of a tumor-producing protoplasm in humans.

Carcinoma within the cervix is a familiar subject to the surgical pathologist and urethral caruncles are fairly common. However, the occurrence of a malignant change in the urethral caruncle is unusual in our experience. In association with a neoplastic lesion of the cervix, it is quite rare. We have studied 66 cases of urethral caruncle during the past 14 years, but all were histologically benign.

Could this lesion have developed by continuity from the cervix? Probably not. Certainly, the absence of cervical ulceration and the clinical impression of an uninvolved cervix favors the opinion that the two lesions are independent in origin. Search of the literature fails to reveal a single report concerning the association of carcinoma of the cervix and carcinoma of a urethral caruncle.[1] However, in a series of 79 women with carcinoma of the urethra, collected at Memorial Hospital, New York,[2] between 1926 and 1965,

* From the Department of Pathology and the Department of Obstetrics at The Mercer Hospital, Trenton.



Figure 1: Carcinoma of the Cervix

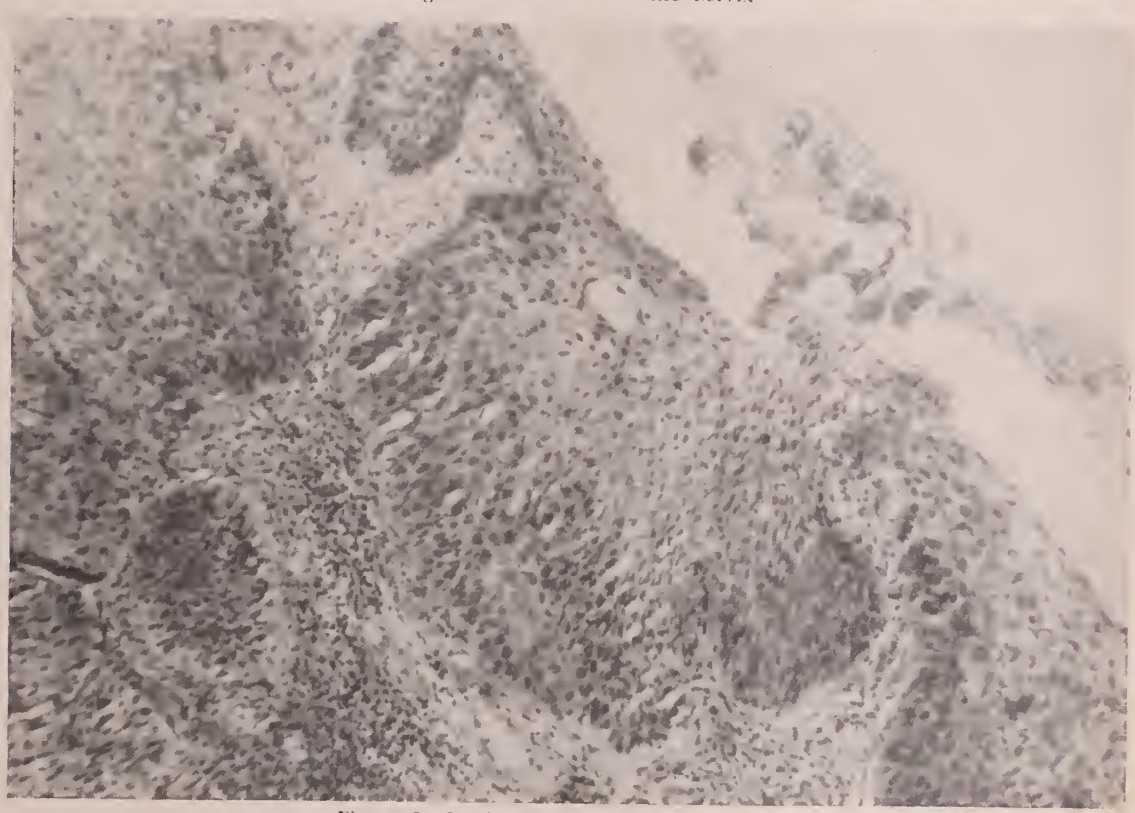


Figure 2: Carcinoma of a Urethral Caruncle

three had epidermoid cervix cancers with concomitant urethral lesions, two of which were epidermoid.

The urethral caruncle is usually a papillomatous, hemangiomatous, or granulomatous type. Primary carcinoma of the urethra is rare. Approximately seven hundred cases have been reported. The vulvourethral is the most common type. Most of the lesions are squamous cell carcinoma which present as polypoid lesions. Sarcoma, melanoma, and lymphoma have been reported arising from the urethral area.[3]

Summary

Carcinoma of the cervix and carcinoma of a urethral caruncle occurring in the same patient is recorded. Attention is directed to the need for a complete history in the study of a disease process. It is important that the clinicians investigate all patients having grade III Papanicolaou smears. The value of having a pathologist study all tissues removed by surgery is again confirmed. This report focuses attention on a rare oncologic entity. Apparently this is the third such case recorded.

References

1. Medical Documentation Service of the Philadelphia College of Physicians (1968)

2. Grabstald, H., *et al.* Journal of the American Medical Association, 197:835 (Sept. 12, 1966)

3. Novak, Edmund and Woodruff, Donald. *Gynecologic and Obstetrical Pathology,* Philadelphia 1967 (Ed. 6.) Saunders, pages 36 to 38.

Photographs courtesy of Thomas K. Rathmell, M.D.

446 Bellevue Avenue

A Life-Time "Blood Bank Account"

The time may come when the first "deposit" of blood for a person's account in a long-term blood bank will be taken from the placenta before his birth. Later in life, he could begin making deposits in the bone marrow bank. This super-cold storage area would preserve supplies of his bone marrow in case he needed it for a bone transplant, or to replace marrow damaged during heavy radiation therapy.

Are these far-fetched, science-fiction ideas? Perhaps, but not necessarily, says Israel Davidsohn, M.D., in the *Journal* of the American Medical Association for December 4, 1967. "Good methods for marrow preservation are already available," he points out. Present accomplishments justify the hope that, with further improvement and simplification of equipment and methodology, red cells and marrow may be preserved indefinitely. It may be possible to grow marrow cells in a test tube. Although there are great difficulties in this today, it may be closer to realization than successful transplantation of other organs, Dr. Davidsohn said.

A main purpose of these long-term blood and marrow banks would be to end the problems of proper matching, sensitizing reactions, and occasional hepatitis infections that are a part of current blood therapy. "There is no better blood available for any one of us than our own," Dr. Davidsohn said. What we need is long-term storage and periodic deposits to ensure everyone all the blood he needs when he needs it. "Storing the blood would not require much more space than safety deposit boxes in banks."

Some of these advances are nearer than others, Dr. Davidsohn emphasized. Growing colonies of one's own marrow cells in a test tube, for instance, is some time away. "But even these are not fantasies," Dr. Davidsohn said. "Their vague outlines can be seen forming on the horizons of medical research.

Hyperbaric oxygenation may provide life-saving relief of hypoxia due to pulmonary disease. This must be closely monitored clinically and instrumentally.

Hypoxia From Acute Lung Failure*

Relief By Hyperbaric Oxygenation

Theobald Reich, M.D. and Julius H. Jacobson, II, M.D./New York

Oxygen is recognized treatment for hypoxia from pulmonary insufficiency. Inhalation of oxygen in high concentrations at normal atmospheric pressure, i.e., one atmosphere absolute (1 ATA), elevates the alveolar concentration of the gas, increases its diffusion through the alveolar-capillary barrier, and raises the hemoglobin saturation as well as the plasma-oxygen content. The magnitude of these changes can be increased further by hyperbaric oxygenation, i.e., by inhaling oxygen in high concentrations at increased atmospheric pressure.

Physiologic Basis

The basis of hyperbaric oxygenation rests on the physical effects of compressing a gas. Most relevant to breathing and oxygenation of blood are that as the pressure of oxygen is increased, its volume decreases, while its solubility in a given solvent and its diffusion increase. Under normal circumstances alveolar air, which determines the gas content of arterial blood, consists of a mixture of 5.6 per cent carbon dioxide, 14 per cent oxygen, and 80.4 per cent nitrogen and water vapor. Thus, at 760 mm Hg (1ATA) alveolar gas tensions are as follows: carbon dioxide 40 mm, oxygen 100 mm, nitrogen 573 mm, and water vapor 47 mm at 37° C). Inhalation of 100 per cent oxygen eliminates nitrogen from the alveolar air and raises the oxygen tension to 673 mm. Carbon dioxide and water vapor contents are not effected since these depend upon the metabolic processes of the body. Inhalation of 100 per cent oxygen at 3 ATA (2280 mm) also does not effect partial pressure of water vapor and carbon dioxide in alveolar air but theoretically does increase the oxygen tension to 2193 mm.

Healthy individuals breathing air at sea level have an arterial blood oxygen content of approximately 20.3 volumes per cent. Virtually all of this oxygen (20 volumes per cent)is carried in chemical combination with hemoglobin, only 0.3 volumes per cent being dissolved in plasma and intracellular fluid of erythrocytes. Since hemoglobin is almost fully saturated with oxygen under these conditions, a further increase in alveolar oxygen tension will not increase the quantity of oxyhemoglobin appreciably. However, the amount of oxygen carried in physical solutions will increase in proportion to the partial pressure of alveolar oxygen. Theoretically, breathing 100 per cent oxygen at 1 ATA would result in the solution of 2 volumes per cent oxygen in the blood (0.3 vol. per cent times 673/100). Breathing 100 per cent oxygen in the hyperbaric chamber at 3 ATA would increase the dissolved oxygen content of the blood to 6.6 volumes per cent (0.3 vol. per cent times 2193/100), the value

*Read before the Section on Chest Diseases, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 12, 1968. This is from the Hyperbaric Facilities and the Departments of Surgery (Vascular), New York University Medical Center (Institute of Rehabilitation Medicine) and Mount Sinai Hospital, New York, New York.

for the difference in arterial-venous blood oxygen content for most organs in the body. Indeed the oxygen tension of mixed venous blood in healthy individuals breathing 100 per cent at 3 ATA is above 100 millimeters. Inasmuch as hemoglobin is saturated with oxygen at this partial pressure of oxygen, venous and arterial blood look equally bright red and cannot be distinguished from each other by visual inspection. While the theoretical calculated oxygen tensions can be approached, their actual attainment in practice is mitigated by such factors as leakage in delivery systems and by uneven oxygenation of the pulmonary blood caused by arterial-venous shunting and uneven aeration of the alveoli. Nevertheless, supersaturation of blood with oxygen under hyperbaric pressures can relieve hypoxia caused by pulmonary disease in which there is excessive arterial-venous shunting or severely reduced pulmonary blood flow. Such pathophysiology may play a significant role in bacterial pneumonia, pulmonary congestion due to heart failure and other causes, pulmonary arteriovenous fistula, large pulmonary embolism, etc. It should be emphasized that hyperbaric oxygenation is not a cure for these diseases, but it may be useful and indeed life-saving in the relief of severe hypoxia resulting therefrom.

By pulmonary diffusion of oxygen we mean the passage of oxygen across the alveolar capillary membrane, i.e., the membranes and humours that exist between the alveolar air and the hemoglobin of the red cells in the pulmonary capillaries.

Any pathologic process which diminishes the effective area of the alveolar-capillary membrane and which increases the thickness of the membrane will impair oxygen diffusion. On the other hand, raising the partial pressure of oxygen in inspired air increases diffusion by increasing the alveolar-capillary oxygen pressure gradient.

Clinical Considerations

Diminished arterial blood oxygen saturation in pulmonary disease is generally caused by one or more of the following disturbances:

1. Abnormal ventilation-perfusion relationships. A disease that causes uneven distribution of inspired air (and, therefore, poor ventilation of some alveoli) will result in extraction of insufficient oxygen by blood perfusing the poorly ventilated portions, provided blood flow to these areas is also not reduced. Disease in which such pathophysiologic processes may operate, i.e., in which there is poor ventilation of well perfused areas, include asthma and obstructive emphysema.

2. Alveolar hypoventilation. A disease that causes a decrease in respiratory excursions (tidal volume), uneven ventilation, or increased dead space will result in insufficient ventilation of the alveoli and systemic hypoxia. Common causes include depression and injury of the respiratory center, neuromuscular or skeletal disease such as poliomyelitis, myasthenia gravis, trauma, kyphosis (in which the bellows action of the chest and diaphraghm are weakened or made ineffective), compression of the lung by air or fluid in the thoracic cavity which reduces functioning lung tissue, and by diseases associated with greatly increased work of breathing as in obstructive emphysema and diseases causing uneven distribution of inspired air also as in emphysema.

3. Arterial-venous shunting (venous admixture). When a significant portion of the blood flowing through the lung is not exposed to oxygen, various degrees of hypoxia ensue. Excessive admixture of unoxygenated venous blood with oxygenated blood may occur in intrapulmonic anatomic shunts as hemangioma, or functional shunts in pulmonary consolidation due to pneumonia and edema, atelectasis or pulmonary compression due to various causes, various pneumoconeoses, and the like.

4. Reduced oxygen diffusion due to "alveolar-capillary block." Any disease process which increases the thickness of the composite "membrane" separating the air in the alveoli

from the hemoglobin of the red cells in the pulmonary capillaries will reduce the diffusion of oxygen. Such process occurs in pneumonia and pulmonary edema, various granulomatous diseases such as sarcoidosis, diseases associated with interstitial fibrosis, hyaline membrane disease, and others.

The important practical question is when should hyperbaric oxygenation be considered for relief of hypoxia due to disease of the lungs. The answer is simple: when oxygen content of arterial blood cannot be maintained at required levels after conventional treatment at normal atmospheric pressure. Depending upon the pathophysiology, relief may be provided by measures ranging from merely giving oxygen by nasal catheter to complete artificial ventilation with 100 per cent oxygen through a cuffed tracheostomy tube. The latter form of treatment invariably will correct alveolar hypoventilation and uneven ventilation but on rare occasions will not overcome effects of severe alveolar-capillary block or large functional or anatomic arterial-venous shunts. Under these circumstances, i.e., when conventional treatment will not keep arterial oxygen tensions at levels compatible with satisfactory clinical condition or at least 40 to 50 millimeters, hyperbaric oxygenation is indicated.

Treatment of Pulmonary Insufficiency With Hyperbaric Oxygen

Our treatment of hypoxia from pulmonary insufficiency by hyperbaric oxygenation is based on the consideration that unnecessary and excessive exposure to oxygen at high partial pressures is undesirable and, indeed, toxic. In healthy man the first manifestation of oxygen poisoning is usually central nervous system irritation and convulsions. In severe lung disease with hypoxia, however, it is unlikely that the brain will be exposed to high oxygen tensions. Exposure of the lung on the other hand is unavoidable. Pulmonary oxygen toxicity is characterized by edema, congestion, and extravasation into the alveoli. These changes tend to aggravate hypoxia and give rise to a situation requiring administration of oxygen at progressively increasing pressures to maintain life sustaining arterial blood oxygen tensions. The difficulty with this type of lung damage is that it is insidious in onset and when clinically recognized may not be reversible. In healthy adult man, the period of latency depends to a large extent upon the partial pressures of the oxygen inhaled. Thus, breathing 100 per cent oxygen at sea level may be tolerated for a day or more although signs and symptoms of pulmonary irritation may appear after a few hours. Animal experiments and clinical experience with human patients suggests that at 3 atmospheres pulmonary toxicity can be caused by 100 per cent oxygen in several hours. It is fortunate, perhaps, that in healthy man, central nervous system toxicity becomes manifest first and that this form of oxygen poisoning is totally reversible by terminating exposure to high oxygen tensions. It is our impression, however, that patients with lung disease tolerate high oxygen tensions for longer periods of time than healthy individuals without clinical evidence of pulmonary oxygen toxicity. In any event, if hypoxia is an immediate threat to life, the paramount concern is adequate oxygenation at the moment.

The foregoing considerations have led us to evolve the following procedure for hyperbaric oxygenation in patients with severe hypoxia due to pulmonary disease:

1. A patient with life threatening hypoxia due to pulmonary disease should be accepted for hyperbaric oxygen therapy only when it has been shown that necessary oxygenation cannot be maintained by artificial ventilation with 100 per cent oxygen through a cuffed tracheostomy tube.

2. If hyperbaric oxygenation is to be undertaken, an intra-arterial catheter is inserted to facilitate withdrawal of arterial blood for gas and pH analysis. Baseline blood gas studies are done before increasing atmospheric pressure. Electrocardiographic leads are attached to permit continuous monitoring of heart rhythm and configuration of

the wave forms — particualry the T waves. A urinary bladder catheter is also inserted to permit continuous measurement of the urinary output. Specimen for hematocrit and other laboratory tests are obtained. Medicinal therapy in the hyperbaric chamber is the same as at sea level pressures.

3. The goal of treatment with hyperbaric oxygen is to maintain lowest ambient pressures at which a good clinical response or an arterial oxygen tension of approximately 45 millimeters (of mercury) is obtained. Good clinical response is gauged by the patient's color, disappearance of dispnea, slowing of the heart rate, normalization of blood pressure, improvement of urinary output, normalization of T waves on the EKG, reduction of metabolic acidosis, and improved responsiveness — mental and physical. Pressure in the hyperbaric chamber is increased as rapidly as the patient will tolerate. Patients who are unable to equalize middle ear or paranasal sinus pressures with ambient pressure may tolerate only slow compression rates, punctuated with periods of rest to permit equalization. In unconscious patients, myringotomy is performed, if time permits. Pressurization is stopped usually at 2 ATA (15 psig†) and arterial blood oxygen tensions are measured. If the results are unsatisfactory or if the patient's clinical condition remains poor, atmospheric pressure is increased another ½ atmosphere (7.5 psig†) and evaluation repeated. Further increase in pressure to 3 ATA has not been needed in our experience. Highest pressures are maintained for only a sufficient period of time to permit blood gas studies, nursing of the patient, including tracheobroncheal toilet (tracheal suction), and administration of prescribed drugs. Mild sedation is a useful adjunct in apprehensive patients. In some patients curarization may be required to prevent "bucking" and to maintain smooth, even respiration.

If the patient's condition remains satisfactory at a given atmospheric pressure for a period of 15 minutes or so, pressure in the hyperbaric chamber is reduced gradually by 3, 4, or 5 psig† steps and clinical evaluation as well as blood gas determinations are repeated. Should the lower pressure not be tolerated, the chamber is recompressed to the previous satisfactory level. Reduction of pressure is attempted once again after approximately 30 minutes. Invariably, progressive reduction of atmospheric pressure becomes possible without reduction of arterial blood oxygen tensions. Indeed, as the patient improves, arterial blood oxygen tensions may increase despite dropping ambient pressures. Inasmuch as decompression proceeds at a slow and stepwise fashion, the need to decompress attending personnel according to Naval diving tables is usually avoided. These persons are breathing compressed air rather than pure oxygen in the chamber. At atmospheric pressures above 2 ATA, sufficient quantities of nitrogen from the air become dissolved in the body humours to require decompression according to diving tables in order to prevent the bends.

The process of reducing partial pressure of the oxygen inhaled by the patient is continued even at sea level by substituting air-oxygen mixtures with progressively lower oxygen concentrations for ventilation. Oxygen tensions of 400 mm in inspired air can be endured for indefinite periods.

A cardio-respiratory catastrophe which must be treated with greatest dispatch if life is to be saved is "the chokes." In this form of air embolism, air is trapped in the right side of the heart and pulmonary artery. Symptoms initially may consist only of substernal pain, but shock and collapse ensue quickly. Treatment consists of immediate compression in a hyperbaric chamber to 6 ATA or more if the vital signs do not improve. Decompression proceeds slowly in stepwise fashion at a rate tolerated by the patient and may sometimes last several days. More recently introduced methods for treating air embolism prescribe compression to lower pressures and ventilating with 100 per cent oxygen to accelerate nitrogen washout and absorption of nitrogen bubbles.

†Pounds per square inch, gauge.

We have been asked on numerous occasions whether hyperbaric oxygenation for problems considered in this paper cannot be administered adequately in a one man chamber, i.e., a small chamber which will hold only one occupant usually lying on a stretcher. However, patients who require hyperbaric oxygenation for hypoxia from pulmonary disease are critically sick patients whose best interest is served by *not* removing them from immediate accessibility to physician and nurse.

Clinical Experience

Table I lists patients with various pulmonary diseases with severe hypoxia who were treated in the hyperbaric chamber. Each had dangerously low arterial oxygen tensions even though ventilation at sea level was with 100 per cent oxygen delivered through a cuffed tracheostomy tube with a Bird respirator. Patients 1 and 2 who had severe interstitial pneumonia recovered completely and were discharged from the hospital. The remaining patients were relieved of hypoxia but succumbed to their basic disease process days or many weeks after hyperbaric oxygenation. Arterial oxygen tensions, however, remained at normal or at least satisfactory levels at sea level pressures.

Figures 1 and 2 illustrate relationships between ambient pressures and arterial oxygen tensions in two patients. In both of these figures, frequent trials at decompression are seen. In figure 1 the hypoxia producing processes in the lung are relieved rapidly, and continuous gradual decompression was possible without producing arterial blood oxygen desaturation. In figure 2, on the other

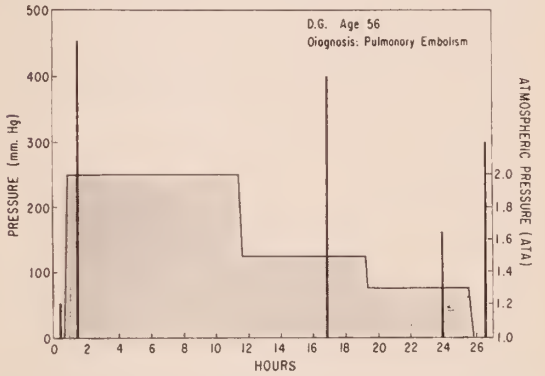


Figure 1.

Ambient pressures (shaded area) and arterial blood oxygen tensions (solid black bars) in a patient with hypoxia from pulmonary embolism and severe congestive failure.

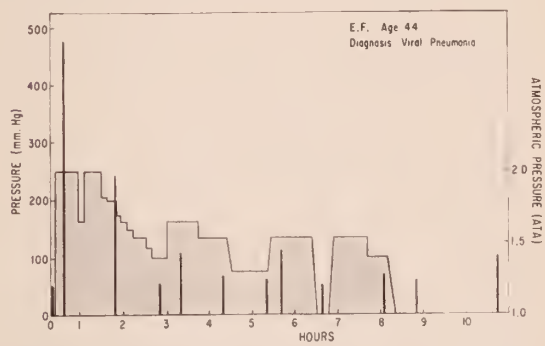


Figure 2.

Ambient pressures (shaded area) and arterial blood oxygen tensions (solid black bars) in a patient with hypoxia from viral pneumonia.

TABLE I

PATIENT	AGE	DIAGNOSIS	Pa O_2 Before Rx	Pa O_2 After Rx	OUTCOME
1	16	Viral Pneumonia	36 (100% O_2)	140–350 (2 ATA)	Discharged
2	44	Viral Pneumonia	51 (100% O_2)	470 (2 ATA)	Discharged
3	56	C. H. F. Pulmonary Embolism A-C block	53* (100% O_2)	460* (2 ATA)	Died 4 mos. later
4	55	Bronchopneumonia	26 (100% O_2)	230 (2 ATA)	Died
5	10	Respiratory Arrest Post-op- Tetrology of Fallot	62 (100% O_2)	550 (2 ATA)	Died 1 mo. later
6	45	Goodpasture's Syndrome	34 (100% O_2)	400 (2 ATA)	Died

*O_2 delivered by mask; all other patients had tracheostomy.

hand, decompression had to be followed by recompression in order to avoid deterioration, once even after the patient had reached sea level pressures. Another patient (#1, Table I) was exposed to hyperbaric oxygen tensions for 24 hours followed by 10 hours of breathing 100 per cent oxygen at sea level, then recompression for another 13 hours. Such prolonged exposure to hyperbaric oxygen may not have been endured by a normal individual.

Summary and Conclusion

Hyperbaric oxygenation may provide life-saving relief of severe hypoxia due to pulmonary disease. This form of treatment is particularly useful in acute lung disease in which the pathophysiologic processes produce excessive veno-arterial shunting (venous admixture) and severe diffusion defects. Such illnesses include interstitial pneumonia, lobar pneumonia, pulmonary edema and congestion, alveolar-capillary block syndromes, etc. Before administering oxgyen at increased atmospheric pressures, it is important that relief of hypoxia be attempted by ventilating the patient artificially with 100 per cent oxygen through a cuffed tracheostomy tube at sea level pressures.

Immediate compression in the hyperbaric chamber is specific and life-saving therapy for patients with "chokes." Decompression in these instances may last for long periods of time.

Close clinical monitoring and frequent measurements of arterial oxygen tensions are necessary in order to maintain a patient at lowest possible ambient pressures compatible with adequate oxygenation.

556 First Avenue

Range of Motion Exercises

Key to Joint Mobility describes exercises to maintain joint motion and thus help patients continue or return to their daily activities. This 48-page manual is published by the American Rehabilitation Foundation. It covers passive, active assistive, and active exercise methods. Several sequences are appropriate for group use, where socialization may increase motivation.

The manual is for health care personnel who plan or carry out range of motion exercise programs — in hospitals, nursing homes, extended care facilities, or community health settings. Primary consideration has been given to the nurse, who often must assume responsibility in this area without assistance from, or consultation with, a physical therapist.

An earlier publication, *Passive Range of Motion and Self-assistive Exercises,* emphasized hand holds and the sequence in which exercises were performed; active range of motion was not included. This comprehensive revision uses a functional approach to make range of motion easier and more meaningful to the patient and nurse.

Authors of the booklet are Patricia Toohey, R.N., B.S., instructor in the Foundation's nursing education program, and Corrine W. Larson, R.P.T., M.S., coordinator of physical therapy education for the Foundation and former physical therapy consultant to local public health nursing and nursing home groups.

Priced at $1.00, the manual may be obtained from the American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota 55404.

NEW JERSEY DOCTORS' NOTEBOOK

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of August:

	August 1968	*August 1967*
Aseptic meningitis	72	37
Primary Encephalitis	7	1
Infectious hepatitis	127	75
Serum hepatitis	34	23
Malaria (military)	4	0
Malaria (civilian)	6	0
Meningococcal meningitis	4	2
Mumps	28	*
German measles	2	*
Measles	26	6
Salmonella	70	78
Shigella	16	15

* Reporting only since October, 1967.

Eastern Encephalitis

During July and August a viral disease of the central nervous system known as eastern encephalitis has caused alarm in southern New Jersey. In the week ending July 26, 1968, three fatal cases of eastern encephalitis were confirmed in horses by virus isolation. By the end of August, 63 confirmed cases of E.E. in horses had been reported from Monmouth, Ocean, Burlington, Atlantic, Cape May, Cumberland, Gloucester, and Camden Counties. And by this time we had, in New Jersey, four confirmed human cases of eastern encephalitis, two of which were fatal. The first was an 8 year old boy from Atlantic County with an onset of illness on July 17. He is currently convalescing with relatives. The second was a 47 year old real estate salesman from Monmouth County, probably exposed in Ocean County, who had an onset on August 11, and who died in a hospital on August 28. The third case was in a 12 year old boy from Cumberland County, also exposed in Ocean County, who had an onset on August 12 and who died 11 days later. The last case was in a 6 month old boy with onset on August 6. He was discharged from the hospital apparently well on August 25.

All of these patients had fever and convulsions and abnormal spinal fluids with 40 to 900 white cells, either predominantly lymphocytes or polys. Confirmation of the diagnosis was by the State Virology Laboratory either by serologic studies or virus isolation.

Viral studies on all cases of suspected viral CNS disease should be submitted to the State Laboratory. This includes an "acute phase" blood, three stools, and a spinal fluid specimen. A convalescent blood specimen should be submitted two or three weeks later. Telephone us immediately about any suspected cases of encephalitis.†

The eastern encephalitis virus is transmitted to both humans and horses by mosquitoes. There is no evidence that the disease can be transmitted directly to man from horses.

The Governor's Interdepartmental Committee on Disease Control has met regularly during August to coordinate activities to control the outbreak. The major effort has been an intensification of mosquito control measures. A horse immunization program against E.E. has also been strongly encouraged.

Trichinosis

The recent decline in the incidence of trichinosis in the United States has been reflected in New Jersey. Since 1965 the number of cases nationally has fallen from 199 to only 67 in 1967. During the same period in New Jersey reported infections dropped from 16 in 1965 to 6 in 1966 and 4 in 1967. Five cases of trichinosis in New Jersey residents have been reported this year. Two of the patients were related. In all of the 1968 New Jersey cases, the suspect food was a commercially processed pork product. Unfortunately in none of these incidents was the suspect meat examined for trichina larvae.

† (609) 292-5590 — after 5 p.m., call (609) 883-4333 or (609) 877-0615.

Diagnosis of trichinosis is based on a combination of clinical symptoms, skin and serologic tests, and muscle biopsy. In this year's New Jersey cases eosinophilia (greater than 5 per cent) was the most common finding, occurring in four of the five cases. Other clinical findings included periorbital edema, myalgia, diarrhea, malaise, fever, chills, and conjunctivitis. Diagnosis was confirmed in three of the 1968 cases by intradermal tests and in one case by serologic testing (Suessenguth-Kline Flocculation). The fifth patient gave a negative skin test but the diagnosis was confirmed by a positive serologic test and muscle biopsy. Because false-positive skin tests are not unusual, serologic and biopsy confirmation are preferred. The State Laboratory is equipped to perform the Suessenguth-Kline Flocculation.

Chloramphenicol Warning

Serious—often fatal—dyscrasias have occurred following the administration of chloramphenicol—usually tradenamed Chloromycetin. Because the amount of chloramphenicol distributed exceeds that to be expected if the drug were used only for its valid indications, the Food and Drug Administration believes that chloramphenicol is often prescribed for conditions for which it is not indicated, even for such trivial conditions as the common cold, and simple infections. The FDA suggests that patients be hospitalized during treatment with chloramphenicol.

The new labeling includes cautionary information on the use of the drug in pregnancy and lactation. Leukemia is added to the previously listed adverse reactions. You are asked to report to the FDA any adverse reactions to chloramphenicol. Such reports, as well as the amount of chloramphenicol approved for marketing, will be regularly evaluated to determine whether further action is necessary to curb the excessive use of the drug.

It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes (leukopenia, reticulocytopenia, or granulocytopenia) before they become irreversible, such studies cannot be relied on to detect bone marrow depression prior to development of a plastic anemia. To facilitate appropriate studies and observation during therapy, it is desirable that patients be hospitalized.

Senator Gaylord Nelson spoke about this in the U.S. Senate on July 22, 1968. Parke, Davis and Company swiftly reacted in a release by Austin Smith, President of the company. Dr. Smith said that certain allegations made by Senator Nelson are misleading.

"Left unchallenged, these statements can cause confusion for sick people; they can cause difficulties for able physicians trying to treat the sick; and, by inference, they malign a company whose reputation for making quality products and truthfully advertising them is second to none. . . So long as the medical profession, through sound practice and supportable research asks for medical assistance, Parke, Davis will try to provide such assistance, whether it be in the form of products or service. . . . For all practical purposes Senator Nelson did not present much, if anything, that was new in his hearings in which chloromycetin was featured. . . . Labeling and promotional material used by Parke, Davis for chloromycetin has been approved by the Food and Drug Administration for years. The drug has been examined in detail twice by a Committee of the National Research Council. More than 350,000,000 warning statements have been issued by Parke-Davis covering the proper use of this drug.

"It still remains one of the most effective antibiotic drugs ever discovered. And, while Parke, Davis and Company does not intend to overpromote this drug, or recommend it for uses not permitted by the Food and Drug Administration, it does intend to remind the medical profession that the drug is still available and does have a useful place in today's medical practice."

Latest Battle On Behalf Of Cigarettes

Senator Magnuson inserted into the Congressional Record some material on the latest defense of cigarette smoking. The following paragraphs were abstracted from the March 27, 1968 Congressional Record.

Mr. Magnuson: Members of the Senate have received inquiries about an article on smoking which appeared in the January 1968 issue of *True* magazine. The article was entitled, "To Smoke or Not To Smoke — That Is Still the Question." It was written by Stanley Frank and it seems to say that cigarette smoking is probably harmless to health.

Reprints of the article have been sent all over the country, to physicians, and other citizens. The note accompanying these reprints gave the impression that the mailing came from *True* magazine. However, on March 13, 1968, I asked the Surgeon General to have it reviewed for me. This review brings into the most serious question the article's accuracy, impartiality, and integrity.

On March 21, the *Wall Street Journal* published an article entitled, "Prosmoking Articles Aren't Necessarily All That They Seem To Be," written by Ronald Kessler. This reveals that articles were sent out to opinion leaders — 600,000 copies in all — not by *True* magazine, but by Tiderock Corporation, a public relations firm hired by the Tobacco Institute; and that Mr. Frank, now an employee of Hill and Knowlton, public relations counsel, rewrote his original article under the pseudonym of Charles Golden, and that this has now appeared in still another publication, the *National Enquirer,* under the headline, "Most Medical Experts Say Cigarette Cancer Link Is Bunk."

This questionable exercise in high-powered public relations may add to the disease and death in our population caused by smoking. I ask unanimous consent that the *Wall Street Journal* article, my correspondence with the Surgeon General, and a comment from the American Cancer Society be printed in the Record.

There being no objection, the items were ordered to be printed in the Record as follows:

(From the *Wall Street Journal,* March 21, 1968)

Prosmoking Articles Aren't Necessarily All That They Seem To Be — Senator Magnuson Asks Inquiry Into Story By Public Relations Writer — Tobacco Men Buy Reprints

(By Ronald Kessler)

It seemed like a windfall for the tobacco industry. "To Smoke or Not to Smoke" was the title of an article in the January issue of *True* magazine. There was little question which side of the issue the article took.

Dismissing statistical evidence of cancer hazards in smoking cited by the Surgeon General, the article concluded, "At the moment, all we can say for sure is that the cause of cancer isn't known and that there is absolutely no proof that smoking causes human cancer."

The story was widely promoted in advertisement, and reprints were mailed to about 600,000 "opinion makers" around the nation. Not surprisingly, five of the six major tobacco companies mailed reprints to their employees and shareholders.

The article couldn't have presented the tobacco industry's case better if it had been written by the industry. And though there's no proof the industry did that, the circumstances surrounding its publication are interesting.

The author, Stanley Frank, is an employee of Hill and Knowlton, Inc., public relations representative for the industry's Tobacco Institute. The reprints, ostensibly a *True* promotion, actually were paid for and handled by Tiderock Corporation, a public relations firm hired by the Tobacco Institute.

More recently, the March 3 issue of the *National Enquirer,* carried a story under the headline "Cigarette Cancer Link Is Bunk." The byline read "Charles Golden," but the author was Mr. Frank.

The tobacco industry is mounting an aggressive new campaign to counter medical evidence that cigarette smoking is damaging to health. A similar dispute arose early last year on publication of the book, *It Is Safe To Smoke* by Hawthorn Books, Inc. The book concluded that it was "safer" to smoke cigarettes having charcoal filters, such as Liggett & Myers Tobacco Company's Lark brand. Several industry sources, in fact, say the book amounts almost to a commercial for Lark. Liggett & Myers denies, however, that it subsidized the book. Hawthorn's chairman, Clement Stone, says, "There are a lot of things that happened with that book that I didn't approve of." He won't elaborate. Hawthorn agreed last April to discontinue sales of the book after the deceptive practices division of the Federal Trade Commission began investigating the advertising.

A well-known Washington journalist was approached last year by a tobacco industry representative and asked if she would put her name on an article attacking the Surgeon General's report on smoking and health. The article already had been written; the plan was to submit it to a national magazine for which she writes frequently. The journalist, who asks not to be identified, refused.

Charles N. Barnard, *True* executive, denies that the magazine produced the reprints. The promotional ads for the *True* article were paid for by individual tobacco companies through Tiderock, according to Reginald B. Wells, executive vice-president of the agency.

The tobacco industry reported record sales and profits last year, but per capita consumption of cigarettes declined for the first year since the Surgeon General's report was issued in 1964.

The following is from the Surgeon General's letter to Senator Magnuson:

The article presents much information not consistent with the known facts. It presents a biased picture of what is contained in the 1964 Report of the Surgeon General. Further, it is misleading in seeming to make the Surgeon General and the Public Health Service the authors of this Report, when in fact it was written entirely by a panel of distinguished non-government scientists *whose selection was approved in advance by the cigarette industry.*

It is important that information on medical matters be presented in as accurate and unbiased a manner as possible and when controversy exists that it be thoroughly and impartially aired. This is especially true in an article on smoking and health. This article failed to do so and we fear that it may encourage people to continue smoking who might otherwise quit, or encourage people to begin smoking who might otherwise have not started. To the extent it does so it increases the risk of disease and death in our population.

(William H. Stewart, Surgeon General)

Public Health Service Report on *True* Magazine Article on Smoking and Health

Massive distribution has been made of an article which appeared in the January 1968 issue of *True,* attacking the evidence indicting cigarette smoking as a health hazard.

The article is by Stanley Frank, who claims to have found contradictions and inconsistencies in the evidence and concludes that the "hazards of cigarette smoking may not be so real as we have been led to believe."

Reprints of the article have been sent to physicians and other opinion leaders throughout the country. Attached to the reprint is a note from the magazine editors stating, "As a leader in your profession, you will be interested in reading this story . . . about one of today's most controversial issues."

The president of the American Tobacco Company has also sent reprints of the article to stockholders of the company with an accompanying letter in which he says, "Despite the many years of intensive medical and biologic research in America and elsewhere, the allegations of the antitobacco critics remain scientifically unproved."

The principal target of the magazine article's attack is the 1964 Report of the Advisory Committee on Smoking and Health to the Surgeon General. The *True* article is the effort of a layman to discredit a scientific report and to question the integrity and the impartiality of scientists and physicians who spent more than a year reviewing all available evidence. The article ignores a review of more than 2,000 additional research studies accumulated since the 1964 Report and presented in a second Report sent to Congress in June 1967. This Report, "The Health Consequences of Smoking," confirms and strengthens the earlier conclusions.

The *True* article's subtitle begins with serious misstatements. It says: "Are cigarettes really 'hazardous to your health' like the package says? Nobody knows. In any case, Americans are smoking more than ever and, curiously, worrying less."

That smoking is a hazard to health is known by practically everybody who has studied the subject. In this country, an overwhelming majority of physicians, the American Medical Association, numerous other professional organizations, and the Congress of the United States have accepted the evidence that smoking is a health hazard. To our knowledge, *no medical or scientific body in the world has taken the position that it is not.*

If the average annual rate of increase in per capita consumption of cigarettes that existed from 1947 to 1953 had continued through 1966, the total U.S. consumption of cigarettes would have been over 700 billion in 1966. Instead, the Department of Agriculture reported an actual figure of 541 billion for that year, a reduction of nearly one-fourth over what might have been expected. In the eleven years from 1955 to 1966, the number of adult cigarette smokers increased by one-sixth, from about 42 million to about 49 million. During this same time, the number of successful ex-smokers more than doubled, from less than 8 million to about 19 million. Americans continue to give up smoking cigarettes at the rate of about one million a year. Are Americans worrying less? The fact that filter cigarettes account for about 70 per cent of all cigarettes now sold in the United States, compared to 9 per cent sold in 1954, suggests that smokers who are unable or unwilling to give up smoking are using filters in the expectation that they are reducing harmful exposure.

The author of the *True* article states in the opening paragraph: "When the Surgeon General of the United States issued his report in January 1964, indicting cigarettes as the chief cause of lung cancer, it figured that smoking would decline, tobacco prices would drop, and cigarette company stocks would do poorly on the exchanges." He then observes that none of this occurred.

The Report was not the creation of the Surgeon General. When Mr. Frank refers to "conclusions reached by Dr. Terry" and "Dr. Terry's abrupt dismissal of other possible causes of lung cancer," he distorts the role of the Surgeon General in the preparation of this study. The Report was the work of an Advisory Committee of ten men, drawn from a list of 150 scientists and physicians representing all the pertinent scientific disciplines. The tobacco industry, among other groups and organizations, was given full opportunity to veto any of the names on the list, no reasons being required.

After more than a year of careful study and evaluation of the entire body of world data on smoking and health, and after reviewing evidence from many witnesses, pro and con, including those from the tobacco industry, and after consulting experts on every facet of the problem, the Advisory Committee concluded that cigarette smoking was a health hazard of sufficient importance to warrant appropriate remedial action.

One member of the Committee, Dr. John B. Hickman, was cited in the *True* article as having some reservations. But Dr. Hickman told a Congressional committee in April 1965: "I agree completely with the Report of the Surgeon General's committee at the time it was issued and I continue to agree completely with the finding of the Report."

The burden of the charges in the *True* article appears to center on these points:

1. The evidence against cigarettes is statistical, and cause and effect association cannot be proved by statistics alone.

2. The cause of cancer is unknown. There is no proof that cigarettes cause lung cancer.

3. Medical opinion is divided on the relationship of smoking to health.

First, as to statistics, the article says on this subject: "Statistics alone link cigarettes with lung cancer, a correlation that is not accepted as scientific proof of the cause and effect. This was admitted in the opening of the report by the Surgeon General's Committee: 'The Committee was aware that the mere establishment of a statistical correlation between the use of tobacco and a disease, is not enough. The causal (sic) significance of the use of tobacco in relation to the disease is the crucial question'."

This sentence is out of context and omits the important sentences adjoining it. The paragraph from which Mr. Frank excerpted the sentence (the omitted sentences are italicized for emphasis) reads in full:

"Each of these lines of evidence (animal experiments, clinical and autopsy studies, and population studies) was evaluated and then considered together in drawing conclusions. The Committee was aware that the mere establishment of a statistical association between the use of tobacco and a disease is not enough. The causal significance of the use of tobacco in relation to disease is the crucial question. *For such judgments all three lines of evidence are essential as discussed in more detail in chapter 3.* These were the Advisory Committee's criteria for judging causality. They were stated several times throughout the Report.

Assuming that the evidence was only statistical, which it clearly is not, the case against cigarettes would still be strong enough to act on. Statistics are essential in every branch of medical science. The distinguished scientist, Warren Weaver, said in *Science Magazine* that, "it is shocking to note that various groups, in order to shake public confidence in statements which they find uncomfortable, are taking the position that it is silly to be impressed by evidence that is 'only statistical' . . . the automatic discarding of evidence because it is statistical is unscientific and wholly unwarranted. . ."

The statistical associations involved in the 1964 Report to the Surgeon General indicated that smoking is a likely suspect, and led directly to further investigations which resulted in the indictment of cigarettes as a health hazard. In other types of evidence, such as pathology, microscopic examination of lung tissue of cigarette smokers has shown that the degree of lung damage and precancerous cellular changes increase greatly with the number of cigarettes smoked.

A second major theme in the article purports to reveal inconsistencies in the evidence linking cigarette smoking to lung cancer. After conceding that statistics on mortality rates "seem to indicate that cigarettes were a menace," the author then writes:

"However, it is difficult to understand Doctor Terry's abrupt dismissal of other possible causes of lung cancer. Scores of surveys have shown that the mortality from the disease in rural areas is less than half the rate in urban communities, for smokers as well as nonsmokers. Many experts attribute this variation to air pollution in industrial centers, and it hardly is a new theory. In 1775, a London surgeon, Percival Potts* reported a high incidence of cancer among chimney sweeps. In recent years, campaigns to reduce air pollution have been spurred by the strong suspicion that components in coal and gas fumes are cancer-inducing agents. Experiments with animals also suggest that the overcrowding typical of living conditions in cities produces stresses that contribute to cancer."

* This referred to cancer of the scrotum which had nothing to do with air pollution.

Dr. Terry had no power to "dismiss" any of the evidence reported by his Advisory Committee. The Committee did not say cigarette smoking was the only cause of lung cancer, but that it was the principal cause. Air pollution is apparently a risk factor since studies have shown that lung cancer occurs more frequently among people who live in cities than among those who live in the country. This was stated in the Report. However, this increase is not nearly as significant as that existing between smokers and non-smokers. *In Iceland, which has some of the purest air in Europe, lung cancer, once a rare disease, has risen with the increase in cigarette smoking.*

The author finds it odd that, although there has been a tremendous increase in women smokers, lung cancer is rare in women, and that their death rate from this disease has remained "almost steady." The lung cancer death rate for women has increased over 50 per cent in the past 14 years, and 400 per cent since 1930.

When lung cancer appears, says Mr. Frank, in the overwhelming majority of cases it is in the lower part of the lung, which is never reached by smoke. This is wrong on two counts: (1) when smoke is inhaled, it circulates, like air, through all parts of the lung and (2) most lung cancer in smokers occurs in the upper bronchial tubes.

Mr. Frank says that most heavy smokers do not contract lung cancer, and a minority who do not smoke also get the disease. If smoking causes lung cancer, he reasons, heavy smokers should contract it earlier than non-smokers, and they don't. All cigarette smokers don't get lung cancer because some smokers are more susceptible than others, some may not have smoked long enough to develop the disease, and other smokers die of other causes before they are stricken. Cigarette smokers develop a different kind of lung cancer than lung cancer victims who do not smoke. By far the most common lung cancer — bronchogenic, or squamous cell carcinoma — occurs almost entirely among cigarette smokers, and rarely in those who have never smoked. In comparison with non-smokers, the average male smokers of cigarettes have approximately a nine-fold risk of dying of lung cancer, and heavy smokers at least a twenty-fold risk.

There is more benzopyrene in cigar and pipe smoke than in cigarettes; yet, says Mr. Frank, cigars and pipes are said to be safer than cigarettes. The degree of inhalation is important to the risk factor, and it seems clear that the smoke from cigars and pipes is rarely inhaled.

The article says since 1914 cigarette consumption in the United States has increased 200-fold, but the incidence of lung cancer has not increased nearly that much despite better diagnostic methods and a greater awareness of the disease. Therefore, says the author, the current mortality rate of 27 per 100,000 population would be vastly greater if cigarettes were guilty as charged. In reality this is exactly what has happened. Per capita consumption has not increased 200-fold, but about 17-fold and during the same period lung cancer mortality has increased 32-fold. In 1914 lung cancer mortality was 0.7 per 100,000 and it is now 22.7 per 100,000. Some of these arguments against the evidence have been advanced by experts whom Mr. Frank mentions in his article. "Surprisingly," he writes, "39 of the 49 medical authorities and statisticians who testified (at Congressional hearings concerning legislation) disagreed vigorously with the report and charged its findings were distorted. Only two of the dissenting experts were connected with the tobacco industry."

It is no reflection on the professional integrity of the dissenting experts to point out that in response to a questionnaire sent to them by Senator Brewster, *all indicated they appeared at the request of the tobacco industry and five of them indicated they received payment from tobacco industry representatives* for their testimony and the time spent in preparing it.

It should also be pointed out that while the dissenting experts spoke for a small minority, and usually for themselves alone, other wit-

nesses, speaking for the major professional groups and voluntary health organizations, clearly represented the consensus of medical thinking throughout the United States.

In the present state of our knowledge, the health consequences of cigarete smoking can be summarized as stated in the 1967 Report, as follows:

1. Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the population. Cigarette smokers tend to die at earlier ages and experience more days of disability than comparable nonsmokers.

2. A substantial portion of earlier deaths and excess disability would not have occurred if those affected had never smoked.

3. If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin.

4. Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chonic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

The American Cancer Society has commented on the *True* magazine article as follows:

We had wondered who was paying for this expensive reprint, for the lists of addresses of opinion leaders, for the first-class postage.

Now the American Cancer Society congratulates the Wall Street Journal for exposing the real source of this mailing. It comes from Tiderock Corporation, a second of the public relations firms employed by the Tobacco Institute. What is presented as a mailing to community leaders by the editors of *True* is now exposed as a massive propaganda effort by the tobacco industry.

Why is this being given this handsome layout, rich paper, and massive distribution to opinion leaders?

Perhaps because it wraps up in lively journalese the tobacco industry's long-time effort to merchandise doubt, to give cigarette smokers the impression that a major scientific controversy rages over whether cigarettes are harmful, that "only statistics" indict cigarette smoking as an extraordinarily dangerous habit.

Controversy there is — on the one hand is the tobacco industry, and now its apologists in *True* magazine; on the other hand a vast body of scientists and physicians. So strong is the evidence against cigarettes that half of the physicians who once smoked cigarettes have licked the habit (100,000 says the Public Health Service). And Congress has recognized the problem by requiring a warning on all cigarette packages.

The article's propaganda lines are familiar to those who have followed the releases and speeches from the tobacco industry. In such form, where the source is known, the self-interest of those distributing the material can be taken into account. However, presented in a general circulation magazine that has been respected in the past, and distributed allegedly by the editors of the magazine as a factual piece dealing with controversy, this article may well mislead the unwary or inexperienced reader.

Thus, Mr. Frank wants the reader to feel that the famous Report of the Advisory Committee to the Surgeon General was in fact Dr. Luther Terry's creation. "Dr. Terry was in a tough spot" he writes, likening him to a district attorney who had to solve a murder. Actually the report was the result of more than a year's study by a most impartial group of scientists, half smokers, half not, selected only after both voluntary health agencies and

the tobacco industry had been given a veto over their choice.

Mr. Frank makes the amazing statement that the Surgeon General's Advisory Committee "had reservations about the conclusions reached by Dr. Terry in the report." To the best of our knowledge this is utterly false.

There has been an interesting, personal development in the life of a committee member that is worth reporting: Louis F. Fieser, Ph.D., Cheldon Emery Professor of Chemistry, Harvard University, developed lung cancer and other diseases a year after the study and told of his experience in the Reader's Digest, "Early diagnosis, preoperative medical treatment, strict abstention from smoking, and skillful surgery had pulled me through. . . . My case teaches two important lessons. The first one is the folly of saying 'It's probably too late to quit now.' I quit at a very late date but it was still in time. Suffering from emphysema, bronchitis, and worsened heart, I was very probably headed for death. But removal of the cause of these conditions — cigarette smoking in my case — stopped the degenerative processes and allowed nature, an extraordinarily powerful ally when given a chance, to start repairing the damage."

Mr. Frank presents a small carefully selected roster of individuals in science and medicine who claim that the case against the cigarette is unproved, or reject the harmfulness of cigarette smoking entirely. By so doing, he gives the impression that the scientific community is seriously divided in judgment. He fails to note that his "sources" constitute an extremely small minority, among those who have considered the question. The United States Public Health Service, the American Cancer Society, the American Heart Association, the American Public Health Association, the Royal College of Physicians in England, and a host of other voluntary health organizations, here and abroad, have considered the evidence (in many cases have worked to produce the evidence through investigation) and are convinced that the cigarette is a distinct menace to health and life itself. The American Medical Association has indicted cigarette smoking as "a serious health hazard."

In several instances, Mr. Frank's assertions can be shown to be flatly incorrect. When he states that (and repeats at the end of the article) "Long exposure to concentrated cigarette smoke *never* (Mr. Frank's emphasis) has produced lung cancer in an experimental animal . . .," he is trapped by the march of research.

Mr. Frank missed the eloquently titled article by R. J. C. Harris and G. Negroni in the *British Medical Journal* of December, 1967, "Production of Lung Carcinomas in Mice Exposed to a Cigarette Smoke and Air Mixture." Lung cancer *has* been produced in a series of experimental animals.

Dr. Oscar Auerback, of the East Orange Veterans Administration Hospital, and colleagues have also gone a long way in demonstration of the harm wrought by the cigarette. In a series of biological — not "statistical" — experiments, Dr. Auerbach has shown that dogs in his laboratory which have been taught to smoke have demonstrated an appalling knack for the lung disease which in human beings would be termed "emphysema:" a disease which in the decade from 1953 to 1963 increased in America some five-fold times. Furthermore, Dr. Auberbach reported "that histologic changes in bronchial epithelium, including dysplastic lesions, can be produced experimentally in animals exposed to cigarette smoke," (*JAMA*, Vol. 199, No. 4, January 23, 1967, pages 241-246; *Cancer*, Vol. 20, No. 12, December, 1967, pages 2055-2066.)

The evidence is far from being "merely" statistical. Indeed, even if scientific findings were restricted to the results of population (epidemiological) studies — and they are not — they would not lack for validity. In denigrating "statistics," Mr. Frank appears to demonstrate something himself: a surprising ignorance of the fact that, properly used and intrepreted, statistics are one of the most powerful tools in the scientific armamentarium.

Medical Tapes By Phone

Pithy, up-to-date information on heart disease, cancer, stroke, and related diseases has been assembled and recorded on tapes by recognized authorities. Devoid of theoretical material which is not of practical use, the tapes are generally four to six minutes in length.

You may call free from any phone in New Jersey. In the northern part of the state [area code 201] simply dial 621-1602 and ask for the tape by number. See the list below. From the southern half of the state (in the 609 code area) dial 201-621-1602. If you want an additional tape just remain on the phone a moment after the first tape has concluded and the operator will return. This service is available 24 hours a day.

Ask For Tape No.

100 **Heart Block and Pacemakers.** ADRIAN M. SABETY, M.D.; *Diplomate of the American Board of Surgery; Attending in Thoracic and Cardiovascular Surgery, Mountainside Hospital and The Hospital Center at Orange.*

101 **Digitalis.** WILLIAM S. WILSON, M.D.; *Professor of Medicine, Chief of Cardiology Section, Rutgers Medical School.*

102 **Acute Pulmonary Embolism.** PAUL B. JENNINGS, M.D.; *Clinical Associate Professor of Medicine, Rutgers Medical School.*

103 **Acute Peripheral Arterial Embolism.** VICTOR PARSONNET, M.D., F.A.C.S.; *Director of Surgery, Newark Beth Israel Hospital.*

104 **Acute Venous Occlusion.** VICTOR PARSONNET, M.D., F.A.C.S.; *Director of Surgery, Newark Beth Israel Hospital.*

105 **Acute Pericarditis.** THOMAS M. MCMILLAN, III, M.D.; *Chief of Medicine and Cardiology, Burlington County Hosptal.*

106 **Problems of Diuretic Therapy.** ARTHUR BERNSTEIN, M.D.; *Attending in Medicine, Newark Beth Israel Hospital.*

107 **Angina Pectoris.** JOHN H. DONNELLY, M.D.; *Attending in Cardiology, Presbyterian Hospital Unit of United Hospitals of Newark.*

108 **Angina Pectoris—Surgical Therapy.** JOSEPH J. TIMMES, M.D., F.A.C.S.; *Professor of Surgery, N.J. College of Medicine and Dentistry.*

109 **Coronary Arteriography.** RUSSELL BRANCATO, M.D.; *Director of Cardiac Laboratories, St. Michael's Medical Center.*

110 **Acute Myocardial Infarction.** MORTIMER L. SCHWARTZ, M.D.; *Professor of Medicine, N.J. College of Medicine and Dentistry.*

111 **Coronary Care Units.** W. AUSTIN TANSEY, M.D., *F.A.C.P., F.A.C.C.; Overlook Hospital, Summit.*

112 **Acute Pulmonary Edema.** TIMOTHY J. REGAN, M.D.; *Professor of Medicine and Director of Division of Cardiovascular Diseases, N.J. College of Medicine and Dentistry.*

113 **Chronic Congestive Heart Failure.** LOUIS F. ALBRIGHT, M.D., F.A.C.P.; *Director of Dept. of Cardiovascular Diseases, Jersey Shore Medical Center.*

114 **Cardiogenic Shock and Cardiac Arrest.** JOHN WINSLOW, M.D.; *Director of Ewing Cardiac Unit, The Hospital Center at Orange.*

115 **Cardiac Arrhythmias Secondary to Myocardial Infarction.** EDWIN L. ROTHFELD, M.D., F.A.C.P.; *Chief, Heart Station, Newark Beth Israel Hospital Institute.*

116 **Cardiac Arrhythmias Arising** *De Novo.* WILLIAM LEFF, M.D., F.A.C.P., F.A.C.C.; *Attending in Cardiology, St. Barnabas Medical Center.*

200 **Cancer of the Breast.** WILLIAM O. WUESTER, M.D., F.A.C.S.; *Director, Green Memorial Tumor Clinic, Elizabeth General Hospital.*

201 **Cancer of the Cervix.** GEORGE P. KOECK, M.D.; *Director of Radiation Therapy, United Hospitals of Newark and St. Michael's Medical Center.*

202 **Cancer of the Lung.** HARRY A. LOTMAN, M.D., F.A.C.S.; *Attending Thoracic Surgeon, St. Barnabas Medical Center.*

203 **Cancer of the Stomach.** LEO H. SIEGEL, M.D.; *Director of Medicine, Attending in Gastroenterology, Presbyterian Hospital, Newark.*

204 **Cancer of the Colon.** PAUL MECRAY, M.D., M.Sc. *Surgery, Cooper Hospital, Camden.*

205 **Leukemia.** JACK S. YORK, M.D., F.C.C.P.; *Chief of Tumor Service, Newark Beth Israel Hospital.*

206 **Lymphoma.** JOHN J. HUDDOCK, M.D., F.A.C.S.; *Research Associate, Sloan-Kettering Institute for Cancer Research, New York City; Assistant Professor of Clinical Surgery, N.J. College of Medicine and Dentistry.*

207 **Cancer of the Ovary.** ROBERT J. ZULLO, M.D.; *Clinical Assistant, Sloan-Kettering Institute for Cancer Research, New York City; Chief of Medical Oncology, St. Peter's Hospital, New Brunswick.*

300 **The Progressive Stroke.** HARRY A. KAPLAN, M.D.; *Professor of Surgery, Chief of Neurosurgery, N.J. College of Medicine and Dentistry.*

301 **The Completed Stroke.** M. BERNARD WINKLER, M.D.; *Director of Neurosurgery, St. Joseph's Hospital, Paterson.*

302 **Rehabilitation of the Stroke Patient.** MARTIN E. LASOFF, M.D.; *Director of Dept. of Physical Medicine and Rehabilitation, Morristown Memorial Hospital.*

400 **Diabetes Mellitus Screening.** ARTHUR KROSNICK, M.D.; *Coordinator of Diabetes, Endocrine and Metabolic Disorders Program, Division of Chronic Illness, N.J. State Dept. of Health.*

401 **Diabetic Acidosis, Coma and Shock.** JAMES MCA'NULTY, M.D.; *Assistant Professor of Medicine, N.J. College of Medicine and Dentistry.*

402 **Dietary Therapy of Atherosclerosis.** MARVIN BIERENBAUM, M.D., F.A.C.P.; *St. Vincent's, Montclair.*

403 **Treatment and Prevention of Pyelonephritis.** LEON SMITH, M.D.; *Chief, Infectious Diseases, St. Michael's Medical Center.*

404 **Diagnosis, Work-Up, Treatment of Chronic Hypertension.** HARVEY E. NUSSBAUM, M.D., F.A.C.P., F.A.C.C.; *Chief, Dept. of Medicine, St. Barnabas Medical Center.*

405 **Acute Hypertensive Crisis.** STEWART F. ALEXANDER, M.D., F.A.C.P.; *Director of Medicine, Bergen Pines County Hospital, Paramus.*

406 **Acute Renal Failure.** NORMAN LASKER, M.D.; *Associate Professor of Medicine and Chief, Renal Division, N.J. College of Medicine and Dentistry.*

407 **Chronic Renal Failure.** SEYMOUR RIBOT, M.D., F.A.C.P.; *Newark Beth Israel.*

408 **Use of Isotopes in Liver and Brain Scans.** WADE N. MILLER, M.D.; *Director of Radioisotope Laboratory, The Hospital Center at Orange.*

AMA Posture On Public Comment

The AMA Board of Trustees is cognizant of the great increase in attention being given in the press and broadcast media to medicine and health care. Our profession is now the focus of one of America's greatest interests. It will constantly be in the spotlight, ending the professional reticence and privacy in which medicine functioned most of the time in the past.

Even though this interest is a tribute to the importance of medicine and the public's desire for its benefits, it brings with it the probems facing any person or organization with a key public position: much of the coverage is critical or displays a lack of understanding.

The Board of Trustees has consulted with AMA staff and public relations counsel on this increasingly important situation. The conclusions that have resulted from this intensive and thoughtful consideration are submitted now:

1. When statements about medicine are misguided or unfair, corrective statements will be issued promptly when the facts are available and an orderly response is possible.

2. We must recognize that the prominence and complexity of medicine in the United States today result in many limitations. Medicine is a constant subject of news and comment, much of which cannot be subject to a later response. Often our replies cannot be carried by the broadcast medium or publication, or at best will be much less prominent than the original coverage. Quite often a responsible statement cannot be issued until the facts have been obtained, and these may be scattered about the country or involve a local situation or require a great deal of time.

3. The frequency and complexity of these matters have increasingly diverted the officers and staff of AMA to reacting to what others do and say. This decreases the ability to work on constructive, ongoing activities that are vital to our future.

4. Staff is developing in written form the best possible anticipatory statements regarding all foreseeable circumstances. By having such matters thought out and documented when a need arises, we will be able to reduce the instances of surprise, decrease the time required for response, and assure consistency in AMA statments on these matters.

5. We will concentrate on building a positive posture by getting understanding for medicine's functions and its positions on various considerations; and by educating the press, broadcasters, and opinion leaders. This will help forestall much misguided criticism and build a favorable climate that will inoculate against susceptibility to unfair criticism.

6. All state and county medical societies are urged to follow these same procedures.

Tops In Public Esteem

Although it sometimes seems as if it were open season on MD's, the fact remains that, according to a survey by *Newsweek* we are still number 1 in public esteem.

The study by Louis Harris and Associates showed 74% of Americans have a "great deal of confidence" in doctors. This is the highest rating received by any of the 17 professional groups listed.

Scoring lowest are those in the communications industries.

The results were drawn from a representative sample of 2,000 individuals throughout the nation as part of a study into the public's attitude toward the business community and its practices.

The occupations and their "confidence scores:"

Doctors 74 per cent
Bankers 70 per cent
Scientists 66 per cent
Military Leaders 65 per cent
Educators 62 per cent
Corporate heads 58 per cent
Supreme Court Justices 54 per cent
Local retailers 50 per cent
Clergy 45 per cent
Congressmen 44 per cent
Federal government leaders 44 per cent
Reporters, publishers 30 per cent
Television heads 26 per cent
Arts 24 per cent
Labor leaders 24 per cent
Advertising men 22 per cent

National Association Of Medical Examiners

A new organization made its debut this spring: the National Association of Medical Examiners. Elected to its Executive Committee were two New Jerseyites — Dr. William Wilentz of Perth Amboy, Medical Examiner of Middlesex County, and our State's Chief Medical Examiner, Dr. Edwin Albano of Newark. Dr. Milton Helpern of New York City became the first president of the new association. Purposes of the organization are: to improve and make more effective the official investigation of sudden, suspicious, and violent deaths under the medical examiner system; to strengthen the administration and operation of the medical examiner system; to encourage the establishment of the medical examiner system in areas where such a system is not in effect; to establish and promote standards for a model medical examiner system; to disseminate accurate information about the medical examiner system, its contributions to the administration of justice and the protection of the health of the community; to advance the professional interests of the medical examiners, including those relating to the administrative and career aspects of their work; to conduct studies, sponsor publications, and undertake other activities and projects designed to assist medical examiners in improving the quality of their work; and to establish and maintain a code of ethics.

Membership in N.A.M.E. is open to all medical examiners, all pathologists, and to any licensed physicians who have responsibilities in connection with the official investigation of sudden, suspicious, and violent deaths.

Are you eligible? If so, write to the National Association of Medical Examiners, 520 First Avenue, New York 10016.

ATTENTION

May we please remind our members that current professional liability insurance coverage under American Mutual will terminate on November 1, 1968. All transfers to our new carrier, Employers Insurance of Wausau, should be achieved without delay. Address applications for new coverage to The Joseph A. Britton Agency, 15 South Munn Avenue, East Orange, New Jersey 07018.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

DERMATOLOGY—Robert J. Carnathan, M.D., 1043 Fernwood Avenue, Maple Shade, New Jersey 08052. Georgetown 1962. Association with dermatologist, or multispecialty group. Available.

GENERAL—Loren T. Burns, M.D., 7 West 14th Street, New York 10011. University of Illinois, 1967. Available.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., Apt. L-2, 121 South Highland Avenue, Ossining, New York 10562. Boston University, 1962. Board eligible. Group. Available.

Edgar Lichstein, M.D., 1777-F Arlin Village Place, Fairborn, Ohio 45324. Downstate Medical Center (NYU), 1961. Board eligible. Subspecialty, cardiology. Available.

Allan M. Sulzer, M.D., APO New York 09254, Tuslog Det. 37. University of Pittsburgh, 1964. Locum Tenen — November 1968-June 1969.

Irving Schiffman, M.D., 2025-A Werner Park, Fort Campbell, Kentucky 42223. Downstate Medical Center 1959. Board Certified. Subspecialty, Cardiology. Group or partnership. Available August 1968.

Raymond L. Hargrove, M.D., 44 Norman Place, Box 113, Tenafly, New Jersey. University of Pennsylvania, 1961. Board eligible. Subspecialty, gastroenterology. Group. Available July 1969.

Stanley Feld, M.D., 24 Heather Road, Watertown, Massachusetts 02172. Downstate Medical Center, 1963. Board eligible. Subspecialty, Endocrinology. Group. Available.

Allen B. Bredt, M.D., 3509 Foxcliffe Court, Randallstown, Maryland 21133. University of Pennsylvania, 1962. Board eligible. Subspecialty, Malignant Hematology and Cancer Chemotherapy. Available July 1969.

OBSTETRICS AND GYNECOLOGY—Arnold J. Halpern, M.D., 516 Almond Court, Hampton, Virginia 23369. Jefferson, 1959. Board certified. Available.

Nicholas J. Criares, M.D., 8121-D Colorado Street, Wurtsmith A.F.B., Michigan 48753. St. Louis University, 1960. Board eligible. Group or associate. Available.

Lawrence N. Margolies, M.D., 12510A Turner Circle, Omaha, Nebraska 68123. Columbia 1962. Board eligible. Available.

Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York 13440. Columbia, 1962. Board certified. Partnership or group. Available, July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital, Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane, Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969.

Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

SURGERY—Dennis M. Wadler, M.D., 245 East 25th Street, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York, Downstate Medical Center (NYU), 1960. Board certified. Pediatric. Available.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part 1. Group or solo. Available.

Robert Wegryn, M.D., St. Mary's Hospital, 89 Genesee Street, Rochester, New York 14611. Cornell, 1963. Board qualified. Group or partnership. Available August 1968.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riverside, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available.

Stanley W. Gensler, M.D., 3rd Surgical Hospital, Dangtam, Vietnam, APO 96372. Albert Einstein, 1961. Board certified. Partnership or group. Available.

William A. Reed, Jr., M.D., 186 Grove Park, Fort Dix 08640. Georgetown, 1958. Board certified. Partnership or group. Available, December 1968.

Albert P. Tarasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

ANNOUNCEMENTS

Courses In Bergen County

"Recent Advances In Internal Medicine" is the title of a lecture series now available at the Bergen Pines Hospital in Paramus. The lectures are at 9:30 a.m. in the auditorium of the hospital. They are held on Wednesdays — October 16, November 6, and December 18, 1968; continuing in 1969 on January 15, February 26, March 19, April 2, and May 7. A star studded faculty has been selected. Also on Wednesday mornings is a practical course on "Endocrinology and Metabolism" — October 23, November 20, and December 4; and in 1969, January 22, March 12, March 26, April 23, and May 21. For details, write to Stuart F. Alexander, M.D., Director of Medicine, Bergen Pines Hospital, Paramus.

Course In Urologic Pathology

From January 6 to February 7, 1969 Columbia University will offer a three-hour-a-day course in urologic pathology on Monday and Thursday afternoons. For more details, write to Melvin D. Yahr, Associate Dean, 630 West 168 Street, New York 10032.

Course In Hand Surgery

Starting on January 20, 1969 the University of Pennsylvania offers a two-week course in the function and surgery of the hand. Tuition is $150 and attendance is limited on a strictly first-come basis. For more information, write to Department of Surgery, School of Medicine, 237 Medical Laboratory Building, Philadelphia 19104.

Ophthalmic Conference in Philadelphia

The Twenty-first Annual Clinical Conference of the Wills Eye Hospital will be held on February 6, 7, and 8, 1969, at the Bellevue Stratford Hotel, Broad and Walnut Streets, Philadelphia. The Bedell Lecture will be given by Dr. Harvey E. Thorpe, Pittsburgh, and symposia on glaucoma will be moderated by Dr. H. Saul Sugar, Detroit, and Dr. Irving H. Leopold, New York. Surgical procedures on live color TV will again be a feature of the meeting.

Inquiries should be addressed to Annual Clinical Conference Committee, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, Pennsylvania, 19130.

Colloquium On Organ Transplantation

On December 7, at the Newark Beth Israel Hospital, the American College of Surgeons (New Jersey Chapter) will conduct an all day session on organ transplantation. Registration opens at 8:30 a.m.

The morning session includes formal presentations by Grady L. Hallman, Jr., M.D. of Baylor University; Albert L. Rubin, M.D. of Cornell; Lawrence Brettschneider, M.D., University of Colorado; and John C. Norman, M.D., Harvard. The afternoon will be devoted to roundtables on renal failure, reimplantation of limbs, pacemakers, and tissue substitutes.

Rabbi Joachim Prinz, Honorary President, American Jewish Congress, will speak on "Moral Issues Of Organ Transplants" at the evening session, which is preceded by dinner (wives invited). For more information, write to the Executive Offices, New Jersey Chapter, ACS, 144 South Harrison Street, East Orange 07018.

Cytology Tutorial For Office Practice

Offered to physicians is a one week course in the use of acridine orange-fluorescence for examination of cytology in office practice, covering pathogenic agents, inflammations, estrogen strength, and an introduction to abnormal cells. One student at a time — hours arranged, equipment provided. Fee: $50. Allan Lazar, M.D., 740 Carroll Place, Teaneck, New Jersey 0766.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
October

9 **Essex County Medical Society**
Combined Dinner Meeting with Auxiliary
"Sex Education in the Schools"

9 **Gloucester County Tuberculosis and Health Association**

9 **Middlesex County Medical Society**

9 **Montclair Community Hospital**
Symposium: "Massive Upper Gastrointestinal Bleeding"

9 **Ocean County Medical Society**

9 and 16 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

9 and 16 **The Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
"Survey of Gynecology"

15 **Warren County Medical Society**

16 **The Academy of Medicine of New Jersey**
Hotel Robert Treat
Newark
Symposium: "Antisocial Personality: The Physician's Responsibility"

16 and 23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Pulmonary Masses"

16, 23 and 30 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

17 **The Academy of Medicine of New Jersey**
Section on Urology
Mayfair Farms
West Orange
"Trauma and the Genito-Urinary Tract"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **New Jersey Gastroenterology Society**
Veterans Administration Hospital
East Orange

23 and 30 **The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital**
"Coronary Artery Disease"

23 and 30 **The Academy of Medicine of New Jersey**
St. Barnabas Medical Center
Livingston
"Survey of Gynecology"

23 and 30 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

30 **New Jersey Society of Internal Medicine**
Hoffmann-LaRoche Inc.
Nutley

November

5 **Hudson County Medical Society**

6 **The Academy of Medicine of New Jersey, New Jersey Academy of General Practice, and Newark Beth Israel Hospital**
"Coronary Artery Disease"

6 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Ferrokinetics"

6 and 13 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

6 and 13 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

7 **The Academy of Medicine of New Jersey**
Section on Pediatrics
Rutgers Institute of Microbiology
New Brunswick
Memorial Program for Charles H. Smith, M.D.

8 **New Jersey Academy of Science**
Rutgers Universiy
New Brunswick
Symposium: "Influence of Cold on Metabolic Regulation"

12 **Bergen County Medical Society**

13 **The Academy of Medicine of New Jersey**
The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 **Gloucester County Tuberculosis and Health Association**

13 **Middlesex County Medical Society**

13 **Ocean County Medical Society**

13 **American College of Physicians**
New Jersey Regional Meeting
Rutgers University Medical School

14 **Essex County Medical Society**

20 **New Jersey State Dental Society**
Semiannual Session

20 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Disturbances of Pituitary Function"

20 and 27 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

20 and 27 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

26 **Hunterdon County Medical Society**

December

3 **Hudson County Medical Society**

4 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Calcium and Phosphorus Metabolism"

4, 11 and 18 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

4, 11 and 18 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

5-6 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Newark City Hospital
Workshop on Culdoscopy

7 **American College of Surgeons, New Jersey Chapter**
Newark Beth Israel Hospital
Newark
Annual Meeting

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

11 **Gloucester County Tuberculosis and Health Association**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

18 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Cardiogenic Shock"

26 **Gloucester County Medical Society**

26 **Morris County Medical Society**

1969
January

7 **Hudson County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 **Muhlenberg Hospital**
and Plainfield
15 "Kidneys and Electrolytes"

14 **Bergen County Medical Society**

15 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"New Aspects of Cor Pulmonale"

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

22 **The Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: "Coronary Care"

22 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Diabetes Mellitus"

22 **Muhlenberg Hospital**
and Plainfield
29 "Infectious Diseases"

27 **Cape May County Medical Society**

28 **Hunterdon County Medical Society**

February

4 **Hudson County Medical Society**

5 **Muhlenberg Hospital**
and Plainfield
12 "Infectious Diseases"

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

14-15 **American College of Surgeons**

18 **Warren County Medical Society**

19 **The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Symposium: "What's New in Cancer"

19 **Muhlenberg Hospital**
and Plainfield
26 "Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Cancer Chemotherapy"

26 to Mar. 1 **New Jersey Academy of General Practice**
Sheraton-Deauville Hotel
Atlantic City
Convention

March

4 **Hudson County Medical Society**

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Bergen Pines County Hospital
Paramus
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

19 **The Academy of Medicine of New Jersey**
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

31 **Cape May County Medical Society**

April

1 **Hudson County Medical Society**

2 **The Academy of Medicine of New Jersey**
Symposium on Gynecology

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

2 and 9 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **The Academy of Medicine of New Jersey**
VA Hospital, East Orange
Dental Symposium

16 and 23 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23	**Bergen Pines County Hospital** Division of Internal Medicine Paramus "Porphyrin Metabolism"
26	**Kessler Institute of Rehabilitation** 20th Anniversary Dinner
May 6	**Hudson County Medical Society**
7	**Bergen Pines County Hospital** Division of Internal Medicine Paramus "Present Day Treatment of Chronic Renal Disease"
13	**Bergen County Medical Society**
14	**Gloucester County Tuberculosis and Health Association**
14	**Ocean County Medical Society**
15	**Gloucester County Medical Society**
15	**Morris County Medical Society**
17-21	**MSNJ Annual Meeting** Haddon Hall Atlantic City
20	**Warren County Medical Society**
21	**Bergen Pines County Hospital** Division of Internal Medicine Paramus "Adrenalcortical Insufficiency"
26	**Cape May County Medical Society**
27	**Hunterdon County Medical Society**
28	**Middlesex County Medical Society**
June 10	**Bergen County Medical Society**
10	**Cumberland County Medical Society**
11	**Gloucester County Tuberculosis and Health Association**
11	**Middlesex County Medical Society**
11	**Ocean County Medical Society**
17	**Warren County Medical Society**
19	**Gloucester County Medical Society**
19	**Morris County Medical Society**

Clinical Convention

American Medical Association

December 1-4, 1968

Miami Beach

203rd Annual Meeting

May 17-21, 1969

Chalfonte-Haddon Hall

Atlantic City

OBITUARIES

Dr. W. Kenneth Clark

Death came on August 19, 1968 to Dr. W. Kenneth Clark, one of the few medical practitioners in Bergen County with a Master in Public Health Degree. A native of Pittsburgh (where he was born in 1909), he received his M.D. at the University there in 1939, and in 1951, a MPH from the distinguished School of Public Health in that city.

Dr. Clark was active in civic affairs and was first vice-president of the New York Metropolitan Chapter of the American Cancer Society at the time of his death. He was on the staff of the Valley Hospital in Ridgewood, where he was adjunct attending physician. He was a general practitioner with special interest in geriatrics. Dr. Clark served in the medical corps of the Army during World War II.

Dr. Harold K. Dwork

At the untimely age of 65, Dr. Harold Dwork died on July 6, 1968. A resident of Hillside, he was a member of the Essex County Medical Society. He received his M.D. in the medical school of the University of Pennsylvania in 1927. Dr. Dwork early specialized in occupational medicine and was considered especially distinguished in the field of industrial toxicology. He was on the staffs of both the Beth Israel Hospital and the United Hospitals in Newark.

Dr. Erwin J. Freundlich

Born in Germany in 1895, Dr. Erwin Freundlich died on July 29, 1968 at the age of 73. He received his M.D. degree at the famous Friedrich Wilhelms University in Berlin in 1920 and came to this country shortly thereafter. He worked largely in the field of industrial medicine and was active in committee work for our Essex County Medical Society.

Dr. Eugene Merliss

Most physicians in the Newark-Hillside area will remember Eugene Merliss. Born in 1884, he attended the Kazan Medical Institute in what was then the Russian Empire. He received his medical degree there in 1912 and shortly thereafter came to the U.S.A., moving almost at once to Newark. He has served the people of Essex and Union Counties for a half century since. Dr. Merliss was a pioneer in gastroenterology, a field in which he had a major interest before it became a recognized medical specialty. He always considered himself — and rather proudly — a family doctor. He was affiliated with both the Newark Beth Israel Hospital and the Martland Medical Center. Dr. Merliss died on August 13, 1968, at the venerable age of 84.

Dr. Donald Zimmer

On August 10, 1968, at the untimely age of 40, Dr. Donald Zimmer of Asbury Park died after a brief illness. Born in New York City, he attended New York University Medical School, receiving the M.D. degree in 1954. After concluding an internship in New York, he was commissioned in the United States Navy where he served from 1955 to 1958, completing a residency in ophthalmology. Dr. Zimmer did further advanced work in his chosen field and then came to Asbury Park for the private practice of ophthalmology. He was on the staffs of both Fitkin Hospital in Neptune and the Monmouth Medical Center in Long Branch.

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BOOK REVIEWS

Surgery of the Aged and Debilitated Patient. John H. Powers, M.D. Philadelphia, 1968, Saunders. Pp. 611 Illustrated. (19.00)

Review of this fine text reveals eighteen chapters of up-to-date information written by one or two authors with long experience. The main theme is well spelled out: the proper surgical care of geriatric patients and the prevention of complications of surgical therapy. Subject matter is complete beginning with the physiology of aging and ending with a chapter on surgical mortality. Recent theories of the aging process are described. Pre and post-operative care, elective and emergency surgery in the aged are fully discussed. Individual chapters deal with fractures and orthopedic disabilities, vascular surgery, cancer, and rehabilitation. Surgical illustrations are good and many graphs and charts are presented.

The book reminds the surgeon of the changes occurring in the geriatric patient, making him aware that surgery of the aged is different and often demands special attention that would not be required in a younger individual. Changes in laboratory values are compared in younger and older persons. Radical treatment and surgery are discussed as well and the importance of conservatism in selected individuals.

This is a well written clinical guide to surgical therapy in aged individuals.

GEORGE F. COWLING, M.D.

Physician Service Patterns and Illness Rates. Helen Hershfield Avnet. Published, 1968 by Group Health Insurance, Inc. Pp. 452. Price not stated.

We all need to know more about patterns of disease. Actually we already have a gold-mine of data — every hospital record room, for instance, and every health and life insurance carrier. What can be learned by a review of these files is suggested by this book which retrieves data from the million files now on record with Group Health Insurance. This text is valuable not only in its direct findings but also in its suggestions as to what can be done by an intelligent and patient analysis of similar reservoirs of data.

We see evidence here that men are more likely to postpone medical care than women; that more emphasis must be placed on medical-office rather than on hospital bed care; that hospital admission rates were not affected by including outpatient insurance benefits; that in the New York City area most physicians are not on the staffs of voluntary hospitals; that more nonradiologists (among M.D.'s) did office x-ray work than was done by radiologists; and that more sophisticated people got more care than less sophisticated ones.

Tabulations and graphs tend to be dull, and here is a book that houses between its covers 31 graphs and 164 tables. However the lively style of the text lightly ameliorates the dreary parade of tabulations.

ABRAHAM LEFF, M.D.

Death in Life. Robert J. Lifton, M.D. New York, 1967, Random House. Pp. 594. ($10.00).

If to win the war, American troops had to invade Japan, the loss of lives (Japanese and American) would have been staggering — probably greater than the number lost by the two atomic bombings. From the American viewpoint, at least, the A bomb looked like a good bargain, if one can calculate that coldly, since a great number of living Americans would now be corpses if the bomb had not been used. However, many Americans still have guilt feelings about this scene. Dr. Lifton's book does nothing to reassure them — and, of course, the author had no such intention.

This is a careful study of survivors of the Hiroshima bombing. There is major emphasis on the emotional effects, but there is a solid chapter on the medical results, with wide differences of opinion about the long-term and genetic sequelae to exposure to the bomb. One physician, for example, is quoted as "finding nothing in the way of significant differences between the exposed and non-exposed groups." He excepts leukemia and cataracts where the liability of atomic radiation seems more widely accepted.

The book is a scholarly one, filled with throught-provoking (but fortunately not entirely guilt-provoking) ideas and a clinical objectivity toward the subject matter. As an intellectual himself, Dr. Lifton is especially interested in the effect of the experience on intellectuals and their reactions to being haunted by this blinding image of death. VICTOR HUBERMAN, M.D.

Rights of the Mentally Ill. Robert A. Farmer. New York, 1967, Arco Publishing Company. 139 Pp. ($4.95)

Current interest in civil rights has raised the question as to whether doctors and lawyers are as conscientious in protecting the civil rights of the mentally ill as we are in protecting the rights of other minority groups. In this brief book, the authors review the rights of the mentally sick with reference to involuntary hospitalization, marriage, voting rights, drivers' licenses, right to do business, and the like. The material on the criminal responsibility of the mentally ill is hurried through in three pages — but otherwise the text is solid, well written, understandable, and accurate. One feature of the book is the presentation of 16 tables which show, in compressed but handy form, the practices in each of the 50 states with reference to civil rights — like right to vote, drive a car, sign a contract, and so on. The text is well salted by discussion of actual cases which illustrate the points made.

The book lights up the current trend to separate committability from incompetency, the problem of giving notice of a hearing to an uncomprehending, depressed, or paranoid person, the atrophy of jury trial in commitment procedures, a hospital's duty to inform a voluntary patient of his right to be released, the legal effect of marriage to or by a mentally incompetent person, the ticklish problem of divorce from a mentally sick spouse (in North Carolina a husband can't divorce a psychotic wife if he is the one who drove her crazy), the balancing of society's right to keep unstable drivers off the road against an individual's need to drive, the effect of mental illness on one's legal right to practice a profession, and a patient's right to make and receive phone calls. If the author had provided us with a bibliography, so that the reader could delve further, the book would have been the most useful manual of its kind.

HENRY A. DAVIDSON, M.D.

Education As Therapy: Suggestions For Work With Neurologically Impaired Children. Ruth Mallison, M.A. Seattle, Washington 1968, Special Child Publications. Pp. 166 ($3.50)

By "neurologically impaired" Miss Mallison means the minimally brain damaged with or without hyperkinesis and communication disorders. Her approach, here, is qualitative and clinical rather than quantitative and theoretical. The book abounds in case histories and illustrations of child drawings and writing. A distinct theoretical approach is reflected in the text. Contrary to some authorities, she is against the "stimulus — free environment" and recommends instead a "stimulus — organized" environment. Here stimuli are presented in an orderly fashion. She emphasizes direction, orderly sequence, habit training, concreteness, step by step approach, and involvement of parents in the educational-therapeutic process. The author stresses the emotional problems confronting the neurologically impaired children, but she rejects the "education here and therapy there" approach.

Therapy and education are viewed as one process attempting to correct not only the academic deficiency but also the motor-perceptual difficulties, self-esteem, and emotional displays. The author includes a bibliography of 47 references which should be viewed as a reading list, because no mention of them is made in the text.

The work is not addressed specifically to the physician, but it will be a valuable text for the pediatrician or neuropsychiatrist dealing with neurologically impaired children. Miss Mallison's rich experience in this field has lessons for all of us about the educatonal-therapeutic process not within the scope of the physician.

EUGENE REVITCH, M.D.

The Quiet Furies, by Elton McNeil, Ph.D. Englewood Cliffs, New Jersey, 1967, Prentice-Hall, Inc. 207 Pp. ($5.95)

When people can cope with their problems, their psychological mechanisms are not visible. But when they react badly to stress, the internal psychic mechanisms are exposed. In this work, Dr. McNeil has presented 20 cases covering a rich variety of psychoneurotic and other emotional disorders. The writing is dramatic and interesting — even the case titles ("The Invisible Sickness" or "Physician Heal Thyself" or "The Old Folks at Home") have an attractive slickness about them. The text goes far toward enabling the intelligent nonprofessional to understand such concepts as the psychopath, the transient situational disorder, the passive-aggressive, the obsessive-compulsive, and so on. Of course, we have been surfeited, perhaps sated, with new books on psychiatric and psychologic problems in the last thirty years and perhaps we are reading too much of a good thing. However, the approach here is fresh, the writing is vivid and the general tone is hopeful. Some of the explanations of the processes are a bit glib or show lack of depth, but for the nonprofessional audience, this may indeed, be as far as one can go.

FELIX UCKO, M.D.

Modern Treatment: Treatment of Obesity, Charles A. Hollenberg, M.D., Editor; **Treatment of Burns,** Charles L. Fox, Jr., M.D., Editor. New York, 1968, Hoeber Medical Division, Harper and Row. Pp. 299. ($16 per year, by subscription)

This paper-back consists of articles on obesity and burns written by various authors. Obesity receives adequate coverage but there is nothing new in treatment. It still consists of four facets: (1) motivation, (2) dietary re-education, (3) psychotherapy, and (4) anorexigenic agents. Obesity is a lifelong disease which can be controlled but not cured. The obese patient is a food addict who must accept dietary restriction as a way of life.

In this text, cardiopulmonary failure of the grossly obese is discussed in detail. The pathophysiology is alveolar hypoventilation which leads to arterial hypoxia and hypercapnia.

The section on burns covers first aid, local therapy, plasma therapy, and the management of respiratory problems. The book includes papers on long term management plastic surgery and psychotherapeutic support of the burned patient.

I recommend this volume for any physician who desires to keep abreast of the latest treatment of obesity and burns.

HARVEY P. EINHORN, M.D.

Great Abnormals. Vernon W. Grant, Ph.D. New York, 1968, Hawthorn Books. Pp. 248. ($6.95)

The nearness of madness to genius has been a favorite theme for centuries. A clinical psychologist here draws in-depth profiles of four creative artists who illustrate this. There is Franz Kafka, obsessed with the idea of man as a helpless bit of flotsam in a sea of hostility; Edgar Allan Poe, in the clutch of nightmares pursuing the theme of beauty in death and life in death; Vincent van Gogh who had curious episodes — maybe epileptic, schizophrenic, or dissociative — of self mutilation and even violence; and August Strindberg, a bedevilled, paranoid playwright. In each chapter, the author goes into great detail tracing the well-springs of their morbid personalities.

J. L. BARONE, M.D.

Organization and Management of Family Practice. American Academy of General Practice, 1968, Kansas City, Missouri. Pp 105. (Price not stated.)

In this manual, the AAGP makes available its analysis of family practice and the family physician. We are told what the specialty is, its history, evolution, content, and future. The work of the family physician is described in detail. Although I have been a family physician for over twenty years (and should reasonably be expected to know what it is I do) I was astonished when I saw it all laid out in a codified fashion.

There follows a discussion of the development, organization, and management of a medical practice. A new physician would be helped to decide upon his type of practice, its location, the office layout, equipment, assistants, procedure, various forms, office policies, insurance, personal financial planning, and the like.

This portion of the manual is a gold-mine and, although slanted toward the neophyte, would be of great value to any physician interested in running his office in the most efficient and productive fashion.

The final section enumerates the various community organizations which can be called upon to aid in the care of a patient and his family.

The manual is legibly printed on good stock and sturdily bound. It would he a valuable addition to almost any medical library.

LEO LEWIN, M.D.



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Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done . . . in a hurry.

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet





"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

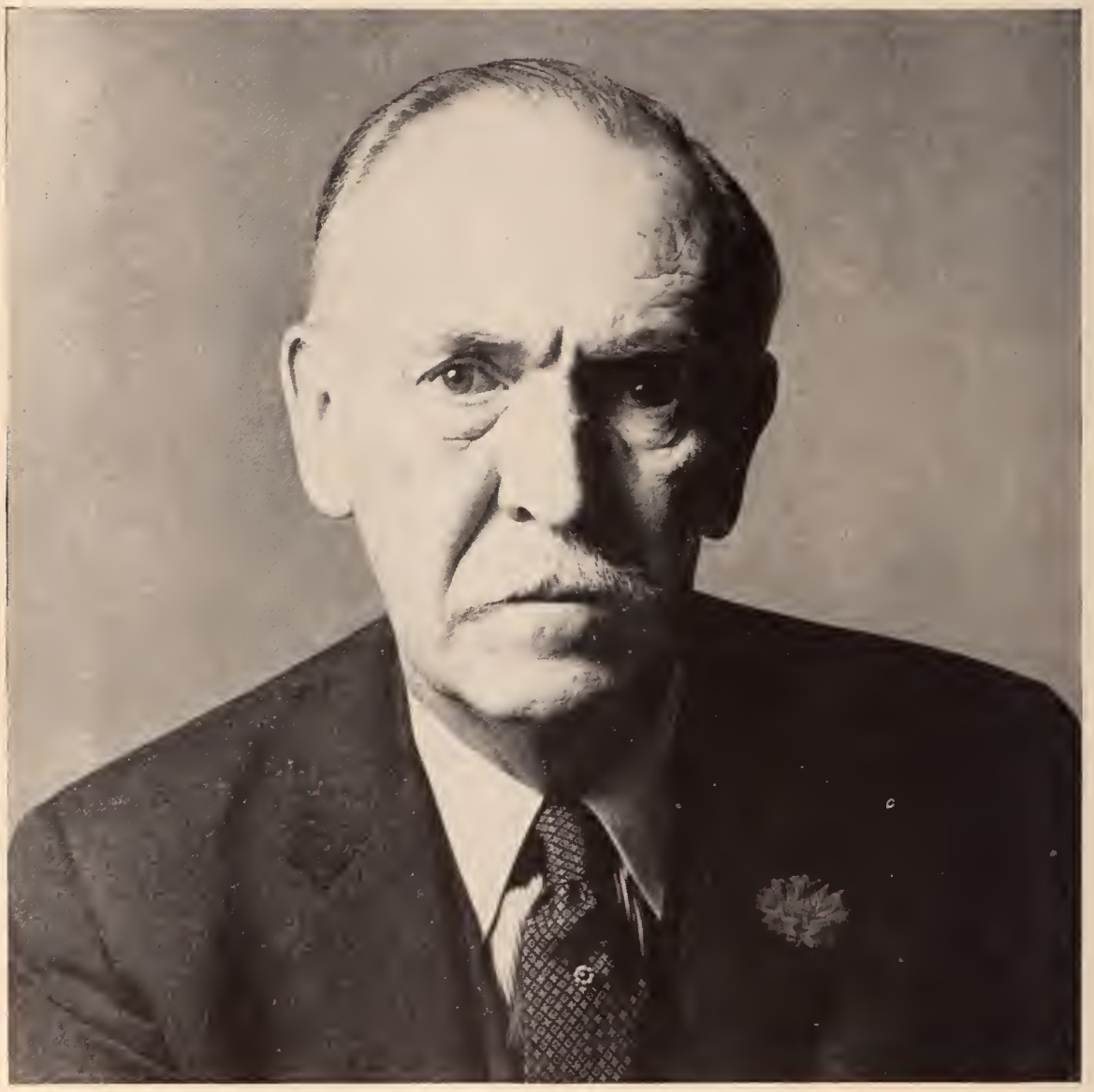
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. He's tired most of the time. Though there's nothing wrong with him organically, he suffers from general malaise. Lassitude has become his way of life . . . vague aches and pains his major concern.

Such a patient has entered the "Mediatric Age"—that stage of his life in which he's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support he's apt to need. MEDIATRIC is intended to help keep him more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
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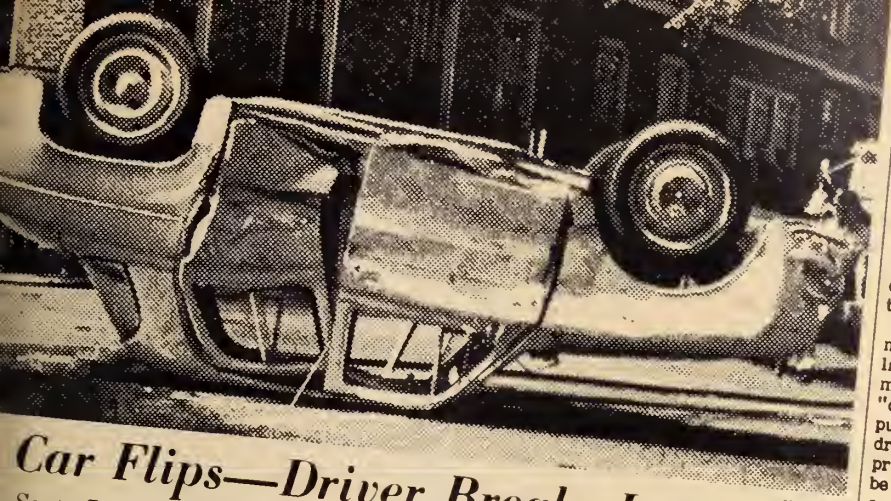
...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Emetrol®
phosphorated carbohydrate solution
emesis control



STAFF PHOTO

Car Flips—Driver Breaks Leg

Sept. 7. John P. Jones of incurred a broken leg today driving

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top

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He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

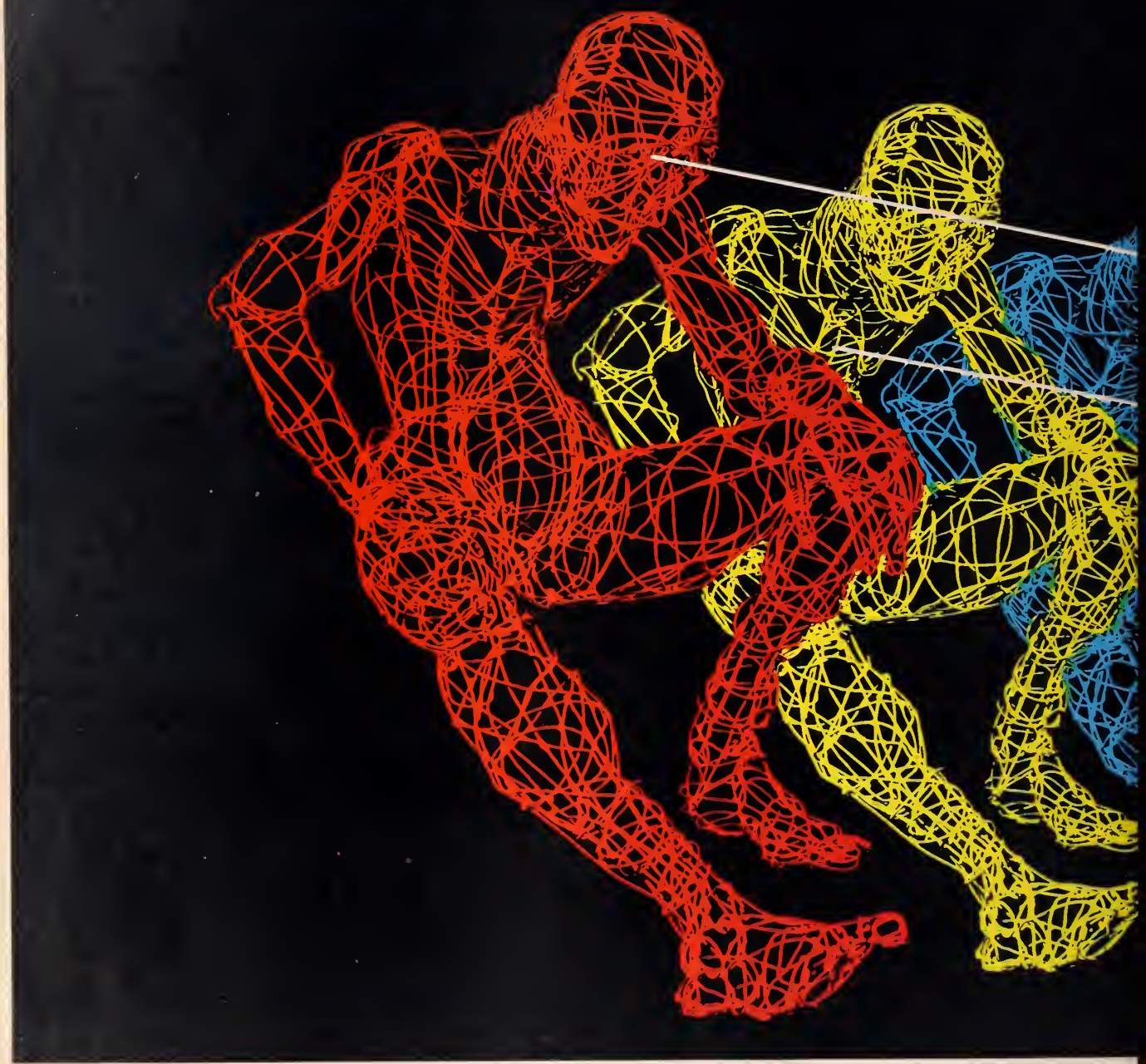
THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

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a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appro investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without ade vitamin B_{12} therapy may result in hematologic remission bu rological progression. Adequate doses of vitamin B_{12} (paren or oral with potent intrinsic factor as in Trinsicon® [hem concentrate with intrinsic factor, Lilly]) usually prevent, h improve the neurological changes.

As with all preparations containing intrinsic factor, resis may develop in some cases of pernicious anemia to the pot tion of absorption of physiological doses of vitamin B_{12}. If ance occurs, parenteral therapy, or oral therapy with so massive doses of vitamin B_{12}, may be necessary. No single men fits all cases, and the status of the patient observ follow-up is the final criterion for adequacy of therapy. Pe



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Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

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linical and laboratory studies are considered essential and are ecommended.

dverse Reactions: In rare instances, iron in therapeutic doses roduces gastro-intestinal reactions, such as diarrhea or consti- ation. Reducing the dose and administering it with meals will inimize these effects.

In extremely rare instances, skin rash suggesting allergy has ollowed oral administration of liver-stomach material. Instances f apparent allergic sensitization have also been reported after ral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a tandard response in the average uncomplicated case of perni- ious anemia.)

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Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

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The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

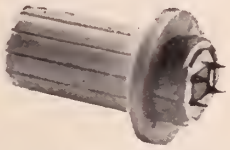
Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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Pneumonia? Leukemia?
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Systemic Fungal Diseases?
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(Histoplasmosis—"The Masquerader")



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That's why we make Novahistine® in two different tablet formulations.

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With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

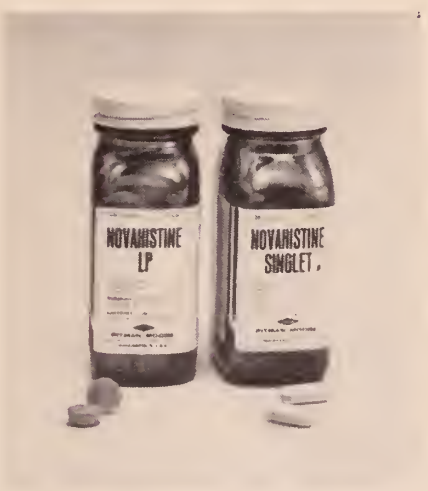
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg, chlorpheniramine maleate, 8 mg, and acetaminophen, 500 mg



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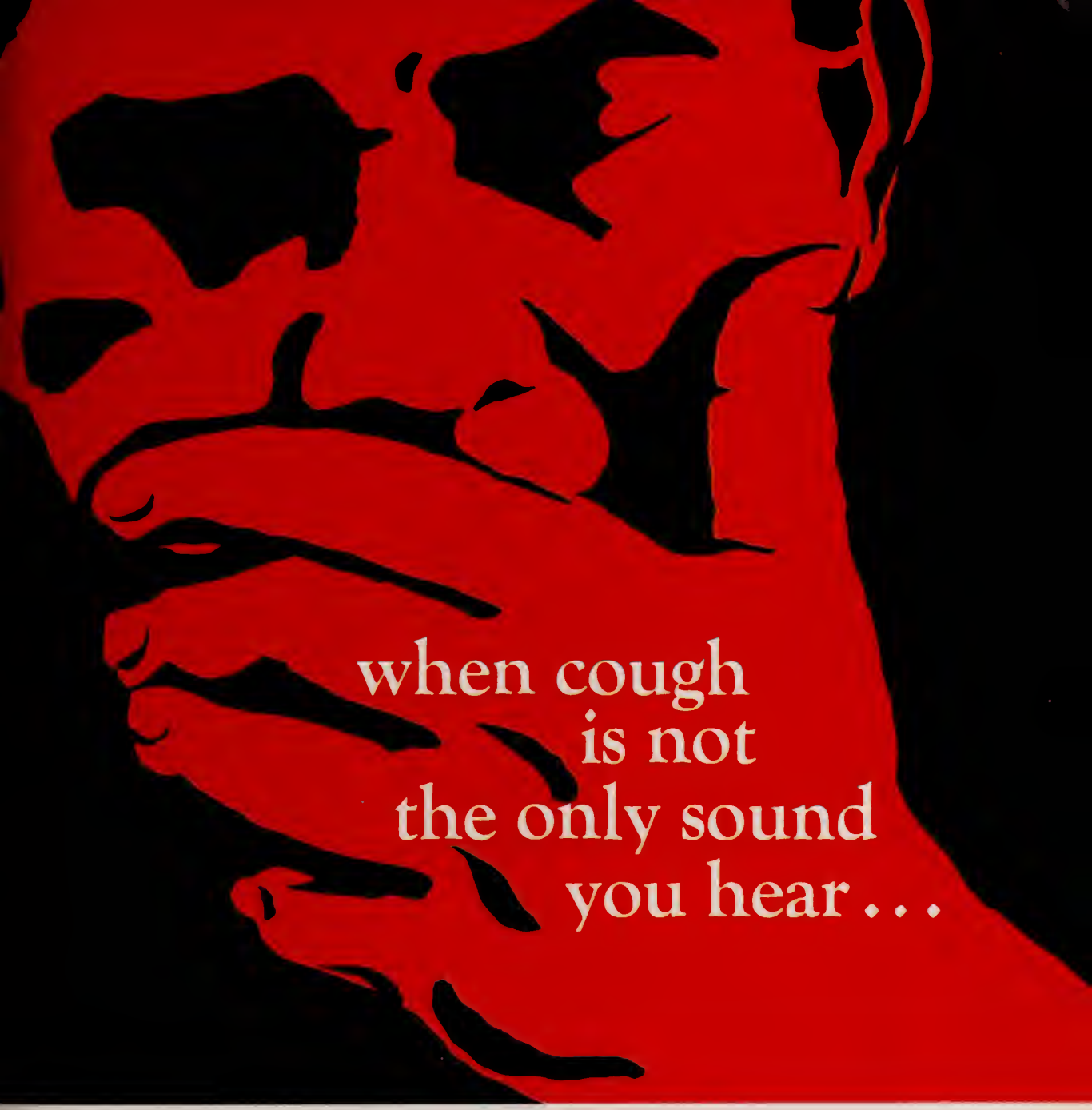


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Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 years): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J.



Eli Lilly and Company
Indianapolis, Indiana 46206



"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

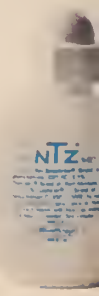
Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



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... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

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Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

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Hematinic with Vitamins and Fecal Softener

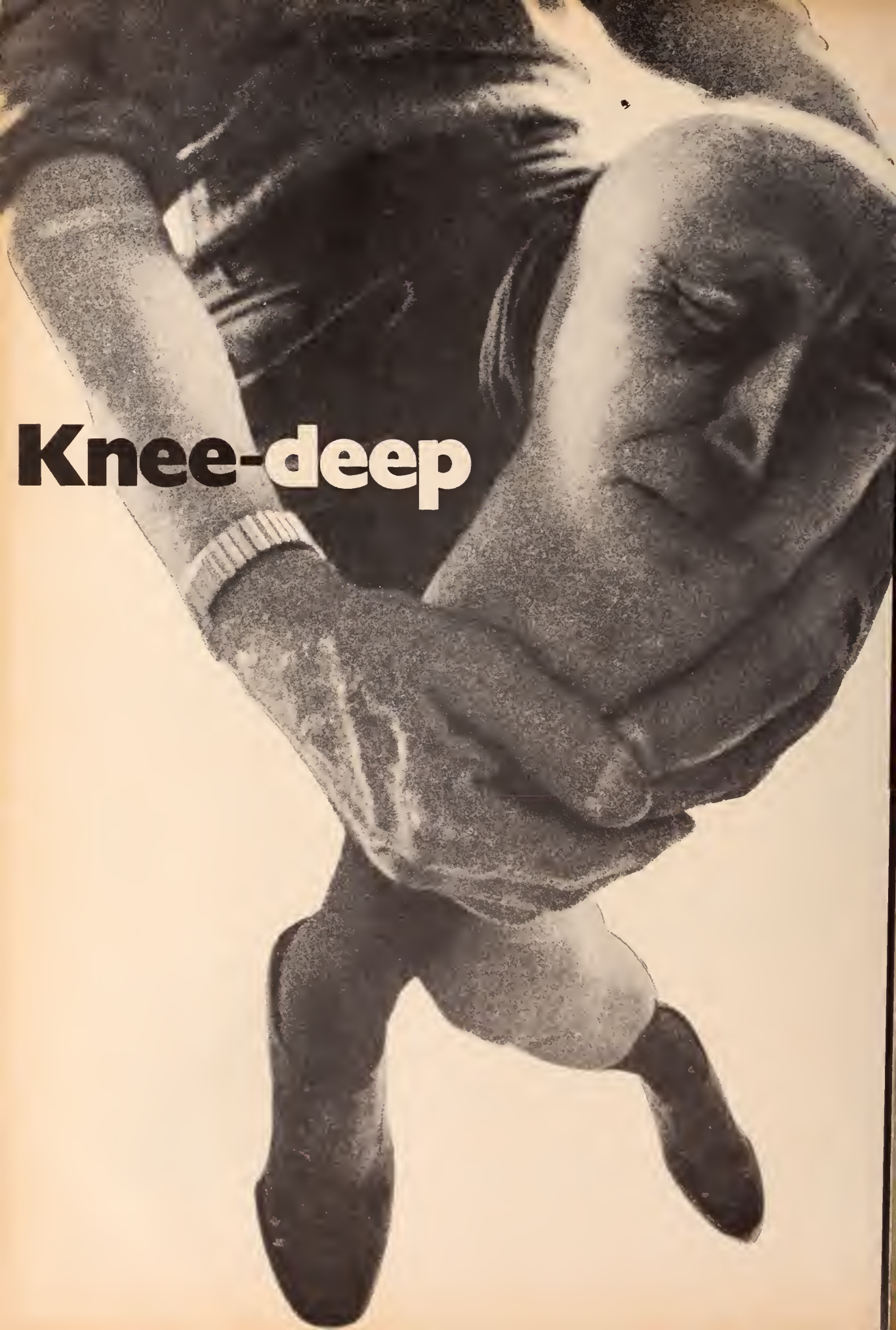
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● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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A Division of American Cyanamid Company
Pearl River, New York 10965


Knee-deep

TA-6006

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

andearil, oxyphenbutazone:
or brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer, perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
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Ardsley, New York 10502

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8

CLASSIFIED ADVERTISEMENTS

ANESTHESIOLOGIST—American, desires association with group or partner. Available October 1968. Curriculum vitae on request. Firm offers only. Write Box No. 100, c o THE JOURNAL.

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OPTHALMOLOGICAL PRACTICE FOR SALE—Includes all office equipment. Shore resort areas, excellent hospital, schools, community and recreational facilities. Call or write Mrs. Ruth Zimmer, 500 Eighth Avenue, Asbury Park, New Jersey 07712. (201) 774-5959.

HOME-OFFICE FOR SALE—Dutch colonial, seven rooms, 1½ baths, wall to wall carpeting. Minutes from major hospitals. Aluminum storm windows, gas heat. $21,500. (201) 678-4185.

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Additional Opportunities See Pages 39A, 40A

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Living quarters and financial help available.

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24 Hours per Day 7 Days per Week

SEE TOPIC LISTING ON PAGE 568

Catalogs have been mailed to all New Jersey physicians; additional copies may be obtained from New Jersey Regional Medical Program, 88 Ross Street, East Orange, New Jersey 07018.



BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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PHILADELPHIA, PENNSYLVANIA 19144

STATE OF NEW JERSEY

Physician—General Practitioner

Mature and licensed or eligible in New Jersey. A State residential school for mentally retarded with 1200 population. New 50 bed hospital. 35 hour work week with vacation, holidays, sick time and insurance benefits. Near resort area and close to Philadelphia and Trenton. Annual salary $15,320 to $18,384 depending on qualifications.

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In addition to the stimulating and rewarding assignments offered in this position, other benefits which you may wish to consider include regular hours, stock savings plan, group life insurance, major medical plan, paid vacation, liberal holidays, retirement plan and edueational assistanee.

If this position is of interest and you wish to pursue this further, please forward a complete resume in eonfidenee, to:

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Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS



New York Academy of Medicine
2 East 103rd Street
New York, New York 10029 C

ready for bed..



..but not for sleep

...because psychic tension may not stop at night

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or w suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effecti amount in elderly and debilitated to prec ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplo hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice skin rash, ataxia, constipation, headache incontinence, changes in salivation, slur speech, tremor, vertigo, urinary retentior blurred vision. Paradoxical reactions suc acute hyperexcited states, anxiety, hallu tions, increased muscle spasticity, insom rage, sleep disturbances, stimulation, ha been reported; should these occur, disco tinue drug. Isolated reports of neutropen jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium (diazepam)

ROCHE

Roche® LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

BALCONY

the JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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NOVEMBER 1968
VOL. 65, No. 11

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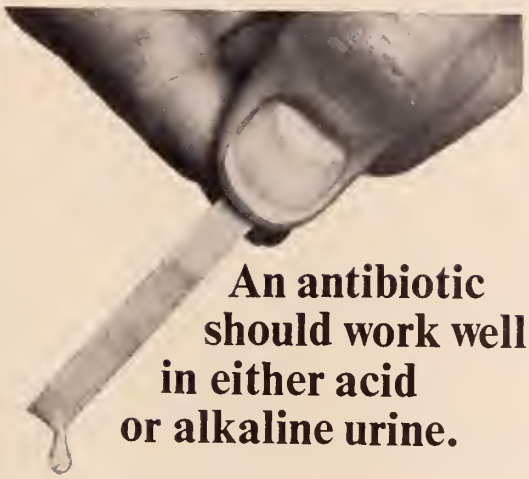
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

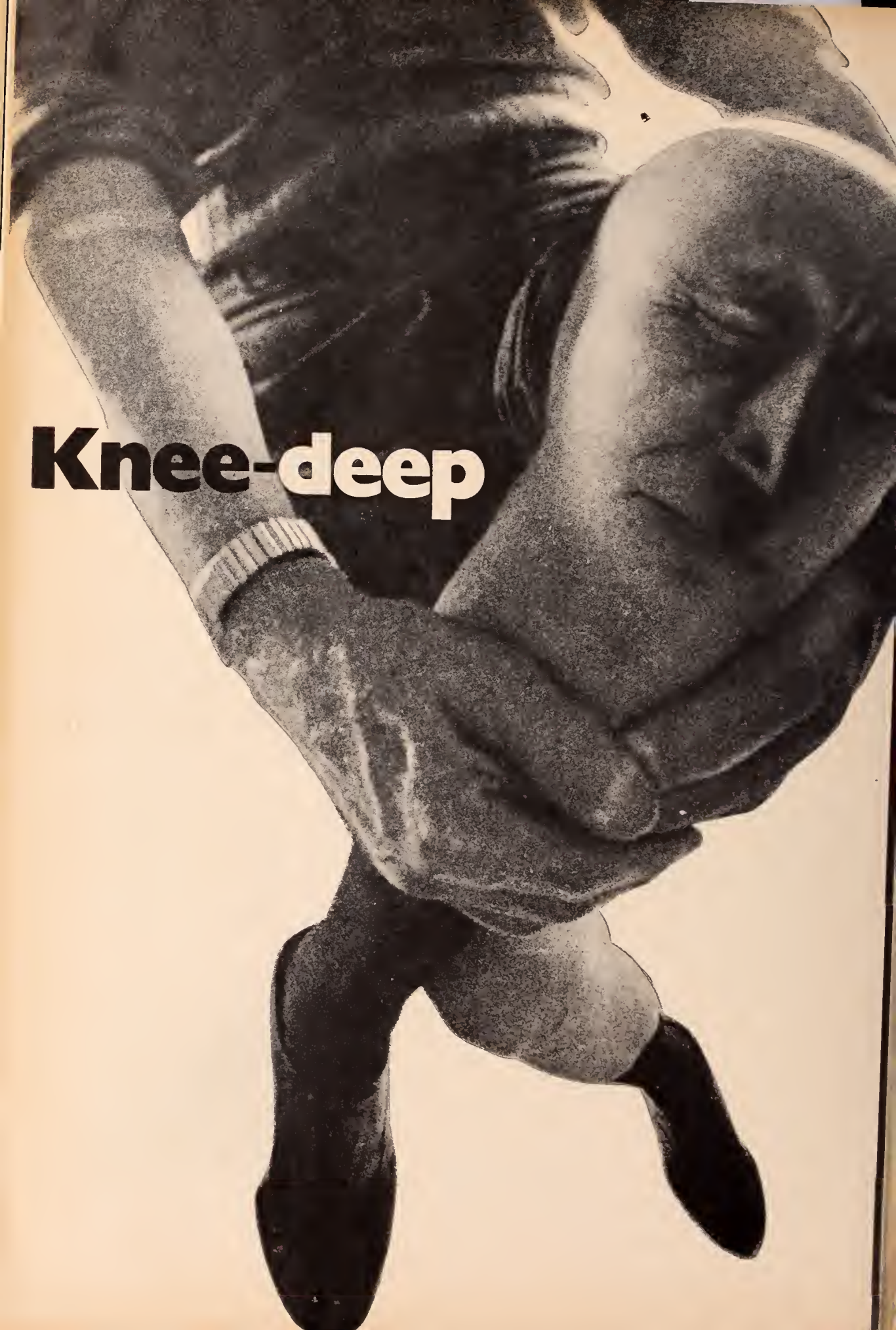
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

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On the next page is a summary of adverse reactions, contraindications, warning and precautions.

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For brief summary see next page.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

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when the diagnosis is depression

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Side effects include drowsiness; dizziness; nausea; excitemer hypotension; fine tremor; jitteriness; weakness; headach heartburn; anorexia; increased perspiration; incoordinatio allergic-type reactions manifested by skin rash, swelling face and tongue, itching; numbness and tingling of limb including peripheral neuropathy; activation of schizophren which may require phenothiazine tranquilizer therapy; ep leptiform seizures in chronic schizophrenics; temporary co fusion, disturbed concentration or, rarely, transient visu hallucinations on high doses; evidence of anticholinergic a tivity, such as tachycardia, dryness of the mouth, blurring vision, urinary retention, constipation; paralytic ileus; jau dice; agranulocytosis.

Careful observation of all patients is recommended. The an depressant activity may be evident within 3 or 4 days may take as long as 30 days to develop adequately, and la of response sometimes occurs. Response to medication w vary according to severity as well as type of depression pre ent. Elderly patients and adolescents can often be manag on lower dosage levels.

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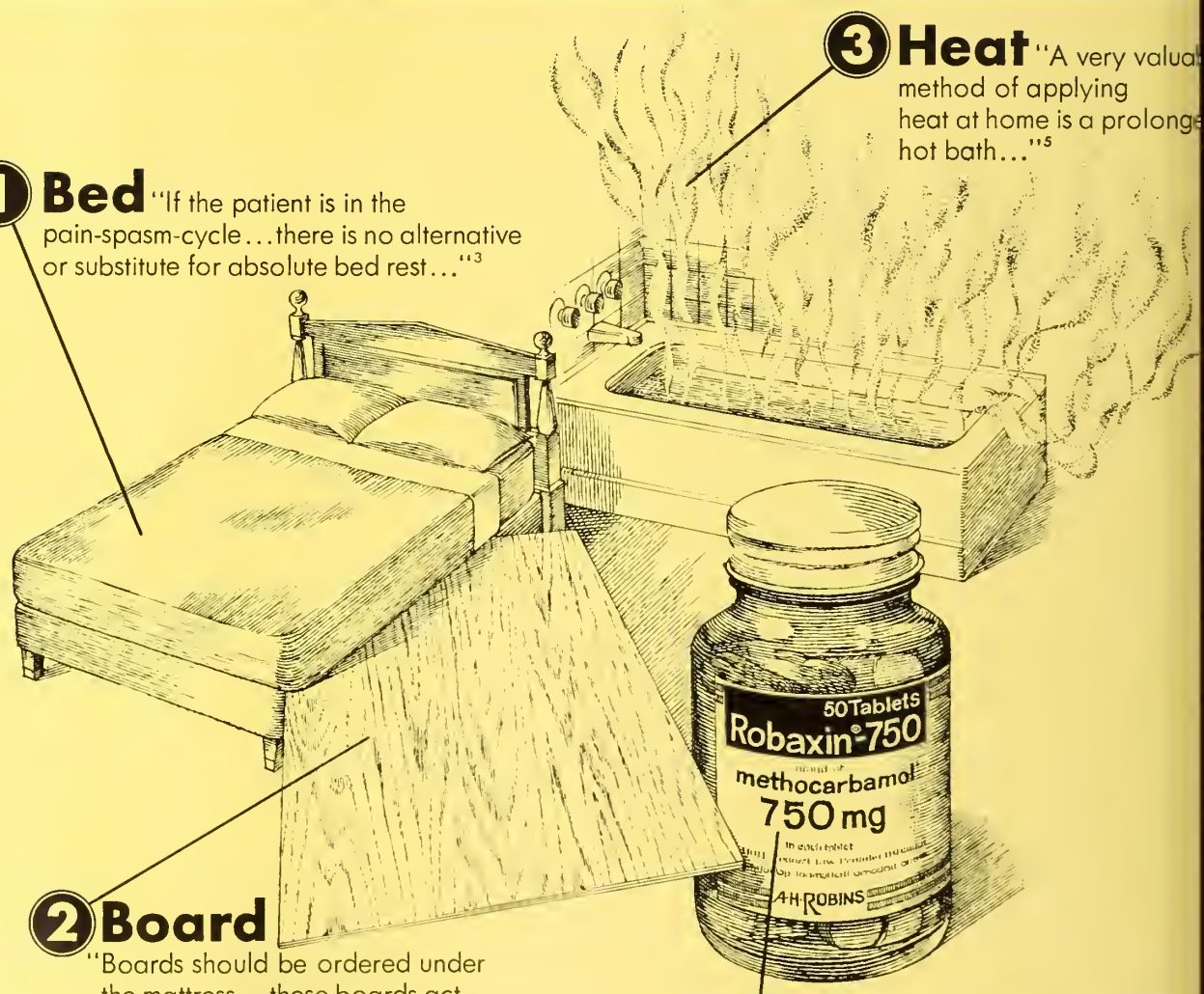
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References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

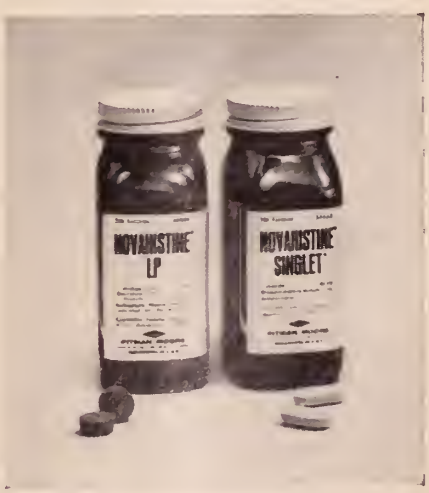
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg; and chlorpheniramine maleate, 4 mg.

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You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

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A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

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In the complex picture of moderate to severe anxiety...



here is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

long recognized for its usefulness in the eatment of moderate to severe anxiety, Mellaril is now also known to be effective gainst mixed anxiety-depression.

Often the symptoms of anxiety states are fficult to sort out—even with the most careful robing. The patient may manifest symptoms of gitation, restlessness, insomnia, somatic mplaints. But what of the depression that may e mixed in the total picture? It is reassuring know that Mellaril may be prescribed—with rong possibilities of success—when there is nxiety alone or a mixture of anxiety nd depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



Louie lost weeks with acute shoulder bursitis. That's a
of pain, stiffness and tenderness...and also a lot of
It might have been different with **Butazolidin® a**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forg

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(8) 46-070-8

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

8U-6210

The Divorced Depressive: "Forty Forgotten

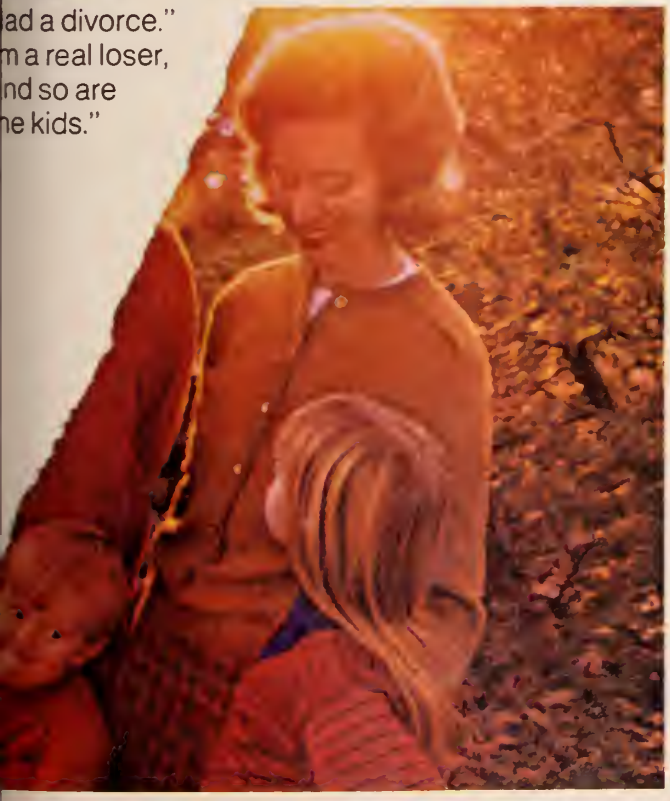
"Had a large wedding."
"Had a fine home and family."



TO-5757

Forlorn"

ad a divorce."
m a real loser,
nd so are
ne kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



801444

Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

when aging brings anguish

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.
Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.
Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

THE VALE CHEMICAL COMPANY INC.

VALE

Pharmaceuticals Since 1922

ALLENTOWN, PENNSYLVANIA 18102

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

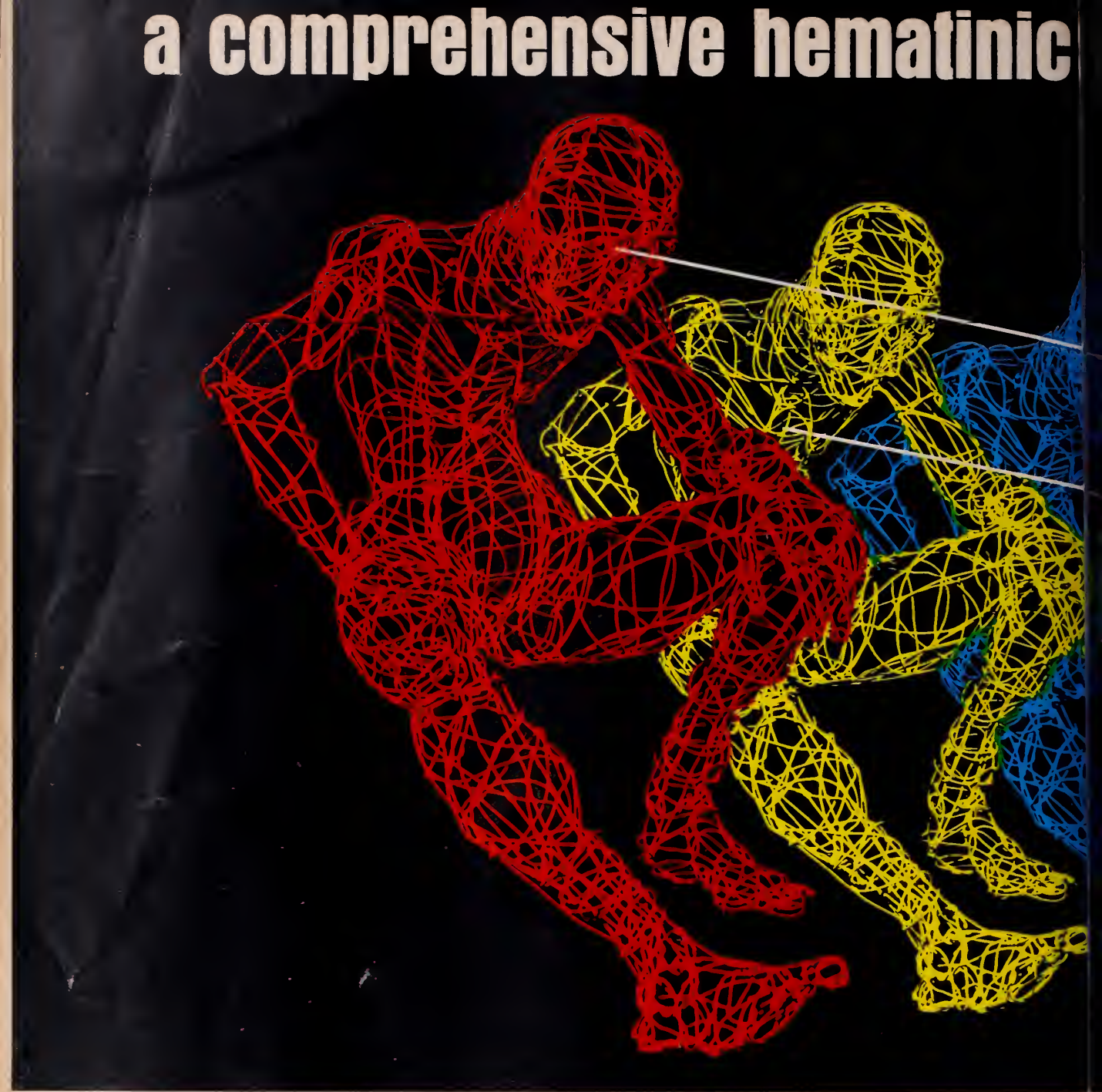
"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

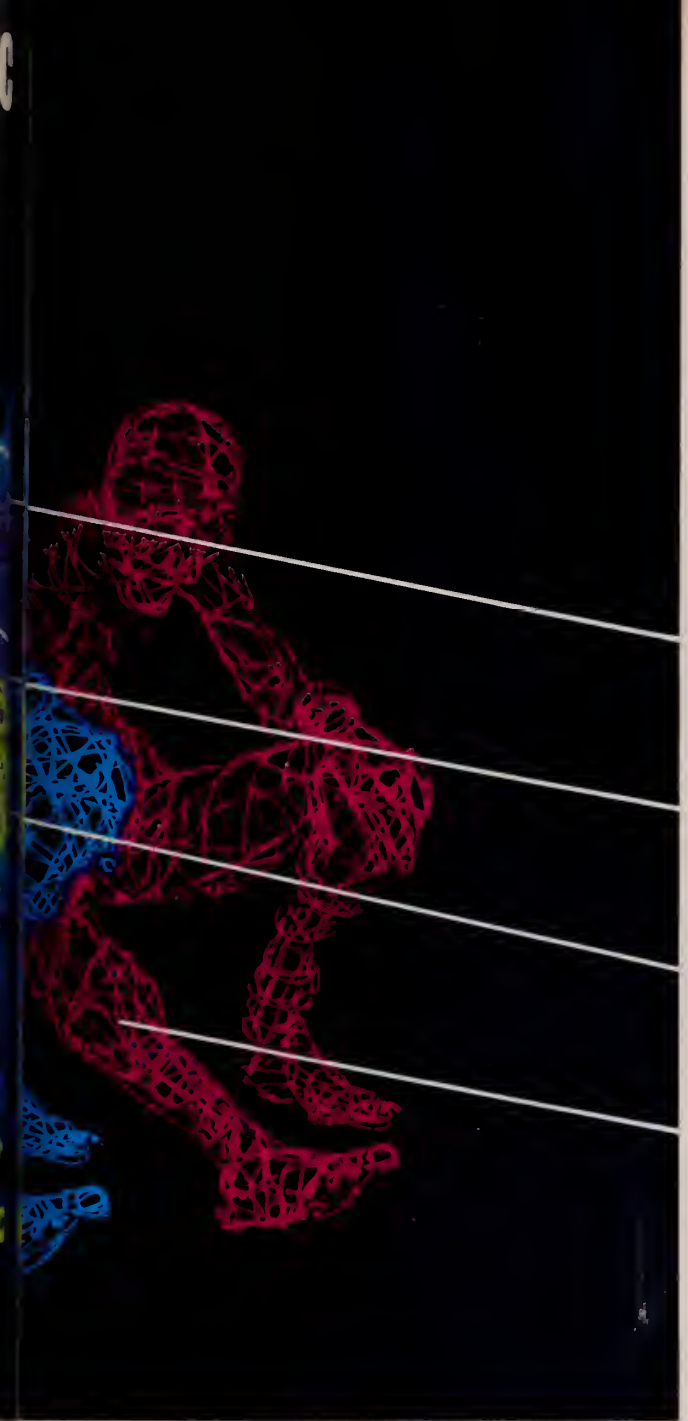
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropria investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequa vitamin B_{12} therapy may result in hematologic remission but ne rological progression. Adequate doses of vitamin B_{12} (parenter or oral with potent intrinsic factor as in Trinsicon® [hematin concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistan may develop in some cases of pernicious anemia to the potenti tion of absorption of physiological doses of vitamin B_{12}. If resis ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single re men fits all cases, and the status of the patient observed follow-up is the final criterion for adequacy of therapy. Period



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

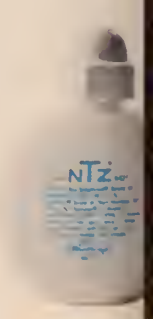
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthr

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, postoperative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens, hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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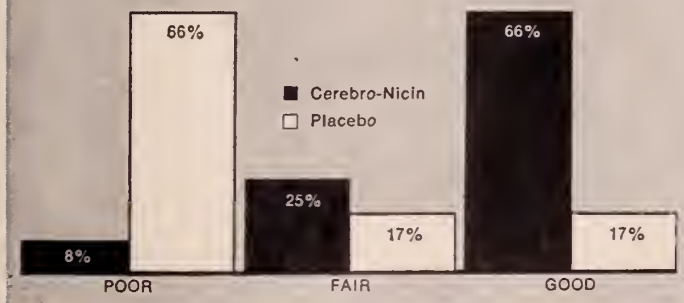
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

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n case you're curious, back in the 1700's paregoric was eing used for diarrhea, but since the state of the pharma-eutical art was extremely primitive, fungus growth in he medication was a problem. Bitter-tasting camphor vas added to prevent such growth and anise oil was dded in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not ontain either of these outdated ingredients.

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Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

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Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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EDITORIALS

November Is Life Month

This is the eighth annual life month for The Medical Society of New Jersey Life Insurance Plan. During this month, members under age 65 are invited to apply for life insurance under this State and County Society approved plan.

More than 1700 of our members participate in the program and actual claim payments to beneficiaries exceed $1,500,000. This year, as last year, one of the member-policyholders who died during the past year had five units of coverage and $50,000 was paid to his beneficiary. The low cost, high quality, and generous limits of the society's life insurance plan make it possible for members to plan their life insurance programs more adequately.

Increased life insurance protection is generally required when your income has increased, your standard of living improved, your responsibilities grown, or your cost of living has gone up. The low net premium of the Society's program keeps the cost of this valuable coverage so low that members can afford to build an adequate insurance program.

Up to ten $10,000 units of term life insurance are available, making the maximum life insurance protection $100,000. The double indemnity provides up to an additional $100,000 for accidental death. There is no extra premium cost for the waiver of premium benefit, double indemnity for accidental death, and guaranteed right of conversion to whole life insurance without physical examination.

Complete information is being sent members by the administrator, E. & W. Blanksteen Agency. Possibly you have already received your letter in the mail. For personal help and information, you may call the agency collect at (201) DE 3-4340.

Iatrogenic Invalidism

A few months ago, there was a pharmaceutical manufacturers' conference in Melbourne. The Australasian College of Physicians was represented by an internist, one Dr. J. L. Frew. He told the conference that, "The Australian doctor is torn between a desire to stick to the tried and understood and a fear of withholding some new discovery." As a result, he said, fifteen per cent of patients in Australian hospitals are suffering from iatrogenic disease.

In reply, the president of the Australian Association of Ethical Pharmaceutical Industry, E. J. Willis, said there is no evidence that Australia is becoming a nation of "pill takers." He added: "We deny the assertion that the population is 'drug happy' because we pharmaceutical manufacturers spend too much energy and money on advertising our products."

Speaking on behalf of the Commonwealth Department of Health, Dr. W. D. Refshauge told the conference that each Australian now gets an average of five new National Health Service prescriptions a year. Now, five new prescriptions may not sound like much for a year but remember the average includes many who take no, or very little, prescription medication, and this must mean that many Australians are taking two or three at a time.

Dr. Frew maintained that physicians overprescribe when they are overworked. "It is easier to treat a patient by his symptoms than to take a careful history and make a meticulous physical examination," he said. "It is becoming an increasingly difficult discipline to decide the best course for a particular patient with a particular disease. But this is the responsibility of the physician in charge of the patient." He also said that there are too many drugs listed under different brand names, all with basically the same effect. This, he said, tends to confuse practitioners.

Of course, there is another side to this and in fairness it must be stated. The American pharmaceutical industry has made available won-

derful drugs and none of us wants to return to the old days when the only way to treat a rising fever was to give sponge baths. Modern drugs alleviate discomfort, dull pain, and save lives, and many of them would never have been developed without the scientific expertise of the research chemists or the risk-taking financial commitments of the drug industry.

There is also a further element here—the patient's expectation that he will get medicine. Our British colleagues say that if a doctor fails to write a prescription, he may be cited on a grievance before the Committee, since the patient feels neglected if he leaves the medical office without medication. Faith in medicines is one of the oldest attributes of the human race—come to think of it, it is peculiar to the human race. (Animals have no such faith.) Sophisticated physicians know that part of the effectiveness of medication lies in the way the doctor dispenses it, or even in the way he hands out the prescription blank. The paper may be transferred to the patient with the casualness of a merchandise order, or it may be a passport to health radiating a charisma of its own. Every doctor has stories of patients who got the pharmacologic effect of a drug almost immediately—long before it should have been effective. Every senior doctor has a favorite story of the patient accidentally getting the wrong medicine or an inert one, but of his deriving much benefit from it. There is an obvious moral here—and a less obvious one. The obvious moral is that the patient's faith in the doctor is a potent weapon. The less obvious one is that if the patient thinks he needs the medicine to get a desired effect, he may suffer from the need for it if he is denied the medicine. Many patients swear that they feel weaker on the day that they miss their vitamins, even though vitamins cure avitaminoses, not fatigue. And here is a path to iatrogenic invalidism. For instance, if a patient takes each evening a capsule of panacein nucleinate and sleeps thereafter, don't tell him that panacein nucleinate doesn't work that way. He is satisfied that it does. Suppose now he has to miss the capsule one night. He will be so worried about not taking his capsule that worry keeps him awake. And this experience drives home the lesson that panacein is a soporific and that he can't do without it. It's a self-fulfilling prophecy. But if that's true with a placebo, it's doubly true—in spades—with a potent drug. Now we have a double dependency: the emotional dependency because the patient thinks he must have the drug; plus the physiologic dependency due to the pharmacologic effect.

A continued source of invalidism is the patient's anxiety, whether generated by either the doctor's words or by his attitude. If the physician reminds a patient of the possible complications or if he imposes an unduly severe regimen on him, this in turn may cause the patient to so guard himself that, in effect, he becomes an invalid. The way you frown when you listen to a heart or take a blood pressure can communicate anxiety and lead to invalidism. And what do we tell an advanced cancer victim who asks: "Am I dying?" One internist suggested: "I never rule out all hope. Recently, a cancer victim asked me to tell her frankly how long she'd last. I replied, 'In a sense, we are all dying. But medicine is constantly finding new ways to treat every disease. We can't predict when *you're* going to die any more than we can predict when *I'm* going to die'."

This, of course, is a highly controversial matter which we aren't going to settle here and now. We don't know whether we will die this year or next. But let's assume that we'll be around for a while yet. Once you think that you are on the last lap, you'll want to pamper yourself. And this is an unworthy kind of invalidism.

Since the aura of the counselor is all important, it is well for the doctor to maintain a posture of dignity, even aloofness. Of course, there is much disagreement about this. For instance, it can be argued that counseling is safer and more effective if it comes from a close friend than from someone who holds himself aloof. The doctor, however, cannot escape from his posture as a physician, except by sacrificing his charismatic role. And when he does that, the advice makes less impact.

ORIGINAL ARTICLES

The value of the angiogram is suggested by this short study.

Angiography In The Diagnosis Of Pulmonary Diseases*

Nicholas J. Demos, M.D./Jersey City

Pulmonary angiography is of great value in the diagnosis of many cardiopulmonary diseases. *Cor pulmonale,* emphysema, and chronic bronchitis may be investigated by this method. In pulmonary arteriogram of primary emphysema, there is rapid diminution in the caliber and number of the branches of the pulmonary artery with wide angled branching. In the arteriogram of moderate chronic bronchitis, the lung fields are unevenly vascularized. The pulmonary arteriogram in *cor pulmonale* due to chronic bronchitis reveals dilated pulmonary arteries. The midpulmonary vessels are larger and the lung fields are more evenly vascularized. Chronic bronchitis without emphysema (but with *cor pulmonale*) shows dilated main and lobar arteries with poor filling of minor branches. In widespread, severe emphysema there is less dilatation of pulmonary arteries. There may be dilated arteries to one lobe with very narrow vessels elsewhere because of the widespread severe emphysema. Huge bullae of one lobe may compress the bigger branches of a neighboring lobe or lobes. The surgical implications of this angiogram are obvious. Diffuse granulomatosis of the lungs can produce *cor pulmonale* which can be easily seen on the pulmonary angiogram.

An unnecesssary operation may be avoided if cancer invasion is demonstrated on a superior venacavogram, or if agenesis or hypoplasia of a lung or a lobe are demonstrated on pulmonary angiogram.

Most important, however, is the contribution of pulmonary angiography in the correct diagnosis of surgical diseases of the lungs and the great vessels. Total anomalous pulmonary venous drainage is one of these surgically correctable lesions. Plain chest x-ray shows mediastinal and cardiac enlargement which in the early phase of the systemic venous injection reveals a left superior vena cava. Later phase of the angiogram reveals the pulmonary veins emptying into a common dilated channel in the left upper chest which empties through a left innominate vein and the superior vena cava into the right atrium with dilatation of all these vascular structures.

Absence of vascular markings can be caused by a huge bulla in the left lower lobe. Excision of the left lower lobe bulla has been successful. The clinical implications of bullous emphysema and its successful surgical eradication are shown by several of our cases.

Pulmonary arteriovenous fistula is another surgically correctable lesion which may be diagnosed with pulmonary angiogram.

*Read before the Section on Chest Diseases, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1968. This work is from the New Jersey College of Medicine and the B. S. Pollak Hospital in Jersey City.

107 Kensington Avenue

Shotgun antibiotic therapy is no longer excusable. We must select the right drug and at the right time . . . and here's an unique guide-line.

Antibiotic Sensitivity Of Pathogenic Microorganisms*

Stanley Burrows, M.D. and Dorothy Gottesman, B.A./Camden

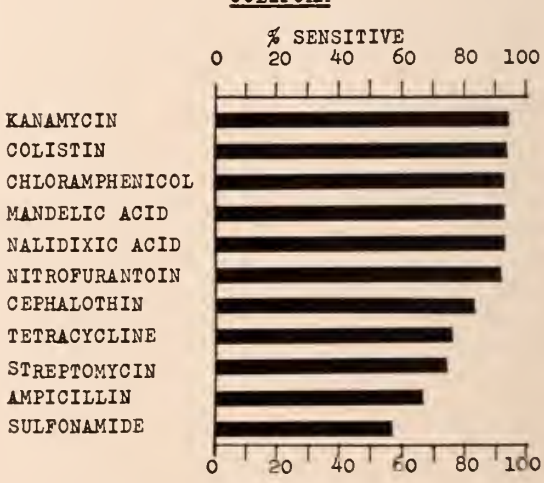
In treating serious bacterial disease, it is important to get the right antibiotic . . . and at the right time. Sensitivity patterns of pathogenic microorganisms may change over a relatively short period of time and an antibiotic originally recommended for the treatment of a particular bacterial infection may no longer be the drug of choice. In addition, several new antibiotics have been introduced in the past few years and although reputable pharmaceutical companies publicize studies of bacterial sensitivity patterns to these new drugs, their literature may be selective or preliminary and may not indicate the complete scope or limitations of the drugs.

We have reviewed our experience with antibiotic sensitivities of bacteria isolated from patients at Cooper Hospital in 1967 to provide a *current* appraisal of sensitivity patterns and to serve as a basis for the selection of antibiotic therapy prior to the determination of complete sensitivity studies for any bacterial isolate.

Method

Following the isolation of a pathogenic bacteria in pure culture, it is streaked heavily on a blood agar plate. Disks containing selected antibiotics are placed upon the streaked plate and the plate is incubated overnight at 37°. A microorganism is considered sensitive to an antibiotic if there is a zone of inhibition of growth around the antibiotic disk following the overnight incubation. No attempt is made to judge relative sensitivity of bacteria by the diameter of zones of inhibition and all disks used contain a high antibiotic concentration (ampicillin 10 mcg., cephalothin 30 mcg., chloramphenicol 30 mcg., colistin 10 mcg., erythromycin 15 mcg., kanamycin 30 mcg., mandelic acid 3 mg., methicillin 5 mcg., nafcillin 1 mcg., nalidixic acid 30 mcg., nitrofurantoin 100 mcg., penicillin 10 units, streptomycin 10 mcg., sulfonamides as triple sulfa 1 mg., and tetracycline 30 mcg.). Mandelic acid, nalidixic acid, and nitrofurantoin are tested only when the pathogenic organism is isolated from a urine culture.

Figure 1



* From the Cooper Hospital in Camden, where Dr. Burrows is chief attending pathologist, and Mrs. Gottesman is bacteriologist.

TABLE 1

ANTIMICROBIAL SENSITIVITY OF GRAM-NEGATIVE MICROORGANISMS

Antibiotic and Sensitivity	*Coliform*	*E. Coli*	*Aerobacter aerogenes*	*Paracolon bacillus*	*Pseudomonas aeruginosa*	*Proteus*
Ampicillin						
Total	1192	35	70	35	334	453
Sensitive	802	31	24	23	16	308
% Sensitive	67	89	34	66	5	68
Cephalothin						
Total	1192	35	70	35	335	454
Sensitive	987	31	63	16	14	301
% Sensitive	83	89	90	46	4	66
Chloramphenicol						
Total	1192	35	70	35	335	453
Sensitive	1111	35	62	29	124	328
% Sensitive	93	100	89	83	37	72
Colistin						
Total	1194	35	70	35	335	455
Sensitive	1120	33	67	24	317	413
% Sensitive	94	94	96	69	95	91
Kanamycin						
Total	1193	35	70	34	334	455
Sensitive	1128	35	69	31	167	433
% Sensitive	95	100	99	91	50	95
Mandelic Acid						
Total	716	22	37	15	208	312
Sensitive	667	21	36	14	193	205
% Sensitive	93	95	97	93	93	66
Nalidixic Acid						
Total	719	22	37	15	214	312
Sensitive	667	22	30	12	14	254
% Sensitive	93	100	81	80	7	81
Nitrofurantoin						
Total	719	22	37	15	214	312
Sensitive	658	22	30	6	3	52
% Sensitive	92	100	81	40	1	17
Streptomycin						
Total	1194	35	70	34	333	455
Sensitive	893	31	59	24	168	315
% Sensitive	75	89	84	71	51	69
Sulfonamide						
Total	1194	35	70	35	335	444
Sensitive	681	21	46	24	192	162
% Sensitive	57	60	66	69	57	36
Tetracycline						
Total	1188	35	70	35	334	453
Sensitive	917	31	59	21	63	45
% Sensitive	77	89	84	60	19	10

Figure 2

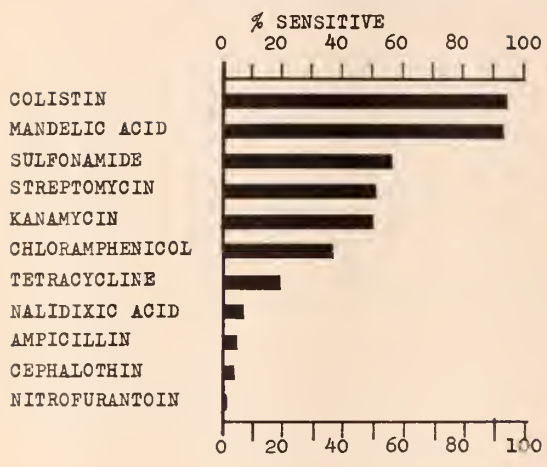


Figure 3

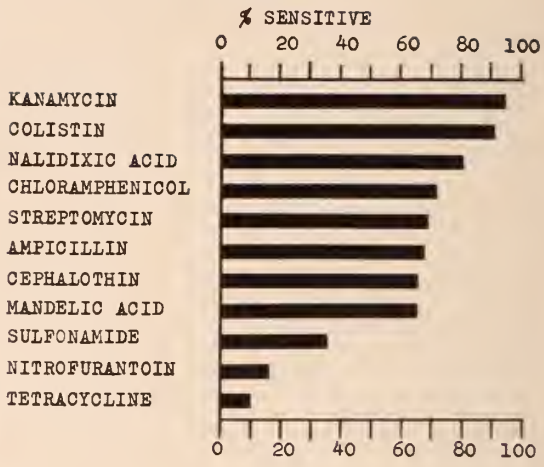


TABLE 2

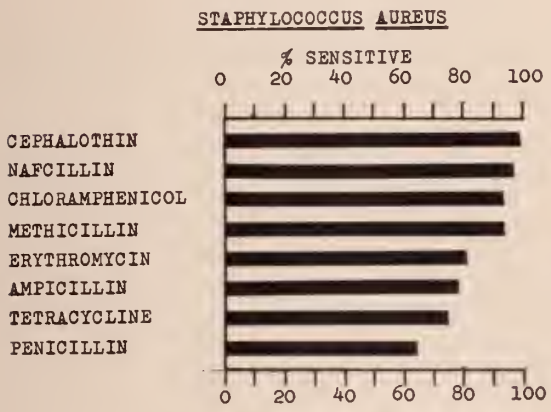
ANTIMICROBIAL SENSITIVITY OF GRAM-POSITIVE MICROORGANISMS

Antibiotic and Sensitivity	*Staph. aureus*	*Staph. albus*	*Strep. fecalis (enterococcus)*	*Beta-hemolytic Strep.*	*Strep. viridans*	*Pneumo-coccus*	*Clostridium perfringens*
Ampicillin							
Total	515	17					11
Sensitive	400	15					11
% Sensitive	78	88					100
Cephalothin							
Total	516	20	147	109	165	63	11
Sensitive	509	20	145	107	163	63	11
% Sensitive	99	100	99	98	99	100	100
Chloramphenicol							
Total	517	20	147	90	165	63	13
Sensitive	480	16	146	89	156	63	13
% Sensitive	93	80	99	99	95	100	100
Erythromycin							
Total	517	20	147	90	165	63	12
Sensitive	419	17	143	90	164	62	12
% Sensitive	81	85	97	100	99	98	100
Methicillin							
Total	514	17					8
Sensitive	479	16					6
% Sensitive	93	94					75
Nafcillin							
Total	516	18					7
Sensitive	501	17					5
% Sensitive	97	94					71
Penicillin							
Total	517	20	147	109	165	63	13
Sensitive	333	14	146	108	162	63	13
% Sensitive	64	70	99	99	98	100	100
Tetracycline							
Total	517	20	147	109	165	63	12
Sensitive	387	13	91	91	133	63	12
% Sensitive	75	65	62	83	81	100	100

Results

The antibiotic sensitivity patterns of the most commonly isolated pathogenic bacteria are shown in Tables 1 and 2. The sensitivity patterns of four major groups of pathogenic bacteria are diagrammatically illustrated in the Figures.

Figure 4



Over 90 per cent of Staphylococcus aureus isolates were sensitive to cephalothin, nafcillin, chloramphenicol, and methicillin. Erythromycin inhibited 81 per cent of these strains, ampicillin and tetracycline 78 and 75 per cent respectively. Only 64 per cent of isolates were sensitive to penicillin.

Streptococcus fecalis (enterococcus), Betahemolytic Streptococcus, Streptococcus viridans, Pneumococcus, and Clostridium perfringens were highly sensitive to cephalothin, chloramphenicol, erythromycin, and penicillin. They were less sensitive to tetracycline, except for Pneumococcus and Clostridium perfringens, all isolates of which were sensitive to tetracycline.

Over 90 per cent of Coliform isolates, which included both E. Coli and Aerobacter aerogenes, were sensitive to kanamycin, colistin, chloramphenicol, mandelic acid, nalidixic acid, and nitrofurantoin. The sensitivity patterns of selected isolates further identified as E. Coli or Aerobacter aerogenes, were similar except that only 34 per cent of Aerobacter aerogenes isolates were sensitive to ampicillin compared to 89 per cent of E. Coli isolates. Both Proteus and Pseudomonas aeruginosa were highly sensitive to colistin, Proteus was also highly sensitive to kanamycin. The resistance of Pseudomonas to most of the commonly used antibiotics is obvious and poses a considerable obstacle in effective therapy.

We recognize that antibiotic sensitivity patterns are variable and past experience does not guarantee any single bacterial isolate will be sensitive to a particular antibiotic. However, we hope that our experience may indicate current probabilities to aid in the choice of antibiotic therapy in the interim between the time an organism is identified and the time when the results of antibiotic sensitivity testing are available.

600 Stevens Street

Scientific Exhibits
203rd Annual Meeting

See pages 619-622 for information and application form for scientific exhibit space at the 203rd Annual Meeting of this Society, May 18-20, 1969, Haddon Hall, Atlantic City.

The travelogue is a declining branch of literature. So it is a pleasure to present one by a member of our Society, designed to whet the appetites of all of us.

MOJA KELA SEKU

Harry C. Goldberg, M.D./Plainfield

Francis Bacon said "reading maketh a full man." A travel diary makes a happy man in the sense that it affords an opportunity to tell others of the pleasures and problems, and chiefly the wonderful opportunity to see how others do things; to understand better and to appreciate our own way of living and its privileges; and it affords the gratification of being a "do-gooder."

I recently was part of a group of fifty doctors and their wives who took a medical tour through Southern Africa, Kenya, and Tanzania. Since Johannesburg is 10,000 miles from New York, you can understand the fatigue which followed eighteen hours flying time aside from several short stop-overs. To my surprise (and chagrin) the lecture schedule started at the South African Institute for Medical Research in Johannesburg at 9:00 A.M. after having gotten into bed about 1:00 A.M. the same morning. The lectures were interesting, to some extent unusual, and presented by competent and effective lecturers. The first, in which I as a dermatologist had unusual concern, was on porphyria. This is seen occasionally in New Jersey, but occurs in enormous numbers in South Africa. This is because in the early 1800's one of the Dutch settlers had this metabolic disorder which he transmitted to his immediate family, and which subsequently became widely disseminated in Southern Africa. No other place in the world has afforded the opportunities for such intensive study as have taken place in the Republic of South Africa. The lecture was enough to awaken most of us and then we became familiar with, not the "coffee break," but the "tea break." This was part of the hospitality arrangement and was planned by the wives of the lecturers and other medical wives.

Some fancy and unusual English type of biscuits were served together with the tea which was either "white" (meaning with milk) or else with limes or lemons. We were to learn to like and to hate tea inasmuch as later in some of the hunting lodges we visited, tea willy-nilly was served together with an awakening knock at the door, often as early as 5:45 A.M.

Our next lecture was a parasitologic study in South Africa together with a wonderful color film of how a collecting trip is carried out. This was followed by a lecture on skin diseases endemic in South Africa. This included cases of ainhum, sporotrichosis, porphyria, relapsing fever, echinococcus, sleeping sickness, and an unusual infectious disease *sinabis*. This is a viral disease prevalent on the West Nile. Such unusual sidelights occurred as a remark by one of the lecturers discussing the territories of South Africa with an abrupt "excuse it, I mean the Republics" or a plea by one of the moderators when a political reference arose, with the remark "please, let's not discuss politics" (in public).

The afternoon was devoted to sightseeing. Although at first I did not realize the significance of large, enormous, man-made piles of slag from the gold mining operations, I was soon to learn the enormous extent of these mounds and the difficult problem they now pose from a scenic viewpoint. On a city tour of Johannesburg the guide mentioned to us that, although we could see these mounds as far as the eye could reach, if we went to the

farthest one, the new horizon would present just as many huge mounds as the ones we now saw. These mounds are spread out over hundreds of miles in the gold mining area. Because of the refining processes used to extract the ore, efforts to grow grass and shrubbery on these mounds are often unsuccessful. Another surprising thing to me was the fact that the Republic of South Africa is bilingual, using both the English and the Afrikaans languages. For example, in our lecture room, one of the signs said "No Smoking-Rook Verbode" and this is found everywhere. The following day we were given a lecture on the geographic pathology of Southern Africa. This was followed by an interesting lecture on South Africa's contribution to our knowledge of the origin of man by a spirited lecturer, Professor P. Tobias. Many of us know that the age of man on earth has been established not as about one million years, but probably closer to three million years, by extensive research work that has been carried out in Africa by Professor Dart and by the work of Dr. and Mrs. Leakey.

That afternoon we were scheduled to visit a diamond mine but this was cancelled because of an opportunity to hear Dr. Christiaan Barnard. Because of his hectic schedule he was not able to appear. Thus we lost an opportunity for both arrangements. Some of our doctors did see Dr. Barnard a few days later on an optional tour arrangement to Capetown, including a visit to the hospital there where they met Dr. Barnard. One of our doctors was a cousin of Dr. Blaiberg and had the opportunity to visit with him in Capetown. He told of the enormous amount of fan mail received by Dr. Blaiberg, one of which included a letter giving him Easter greetings "and hoping that he was still alive at that time."

Another doctor and I were fortunate in having friends living in Johannesburg. My friend was a doctor I had met four years before at the International Tropical Dermatology Congress at Naples. We were afforded a good opportunity to discuss medical practice and medical problems in Johannesburg. My friend had quite a large home with large grounds. The home was wired with burglar devices and there were times when his wife had to carry a revolver. And firearms were available in the house. There was a locked door at the landing of the second floor for additional protection against burglars. The crime rate is very high. The doctor's wife stated that it was nice to have four servants. Since they tend to follow the continental pattern of doing only what their particular assignment consists of, it meant that they had to supply maintenance for four servants, whereas the actual work involved could probably be carried out by two.

One of the laws in the Republic of South Africa (in connection with their *apartheid* policy) is that Bantu servants may not live under the same roof as white people. Accordingly, smaller and simpler quarters are provided in an adjacent but separate building.

The other doctor whom we had an opportunity to meet also had a large home with a number of servants. In contrast to my first friend who had a large "white practice" he had a large "black practice." He said he was very happy with it, but he was unable to speak to most of his patients. The patient was set up for him by a nurse who related the patient's complaints and was able to translate for him. He did a brief examination and then told the nurse what the patient was to do. Most of us would not like such a type of practice. Both doctors were most hospitable to us and put themselves out to show us the cities as well as entertaining and having us dine with them.

On Sunday morning we were treated to one of the main tourist attractions in the city, seeing authentic tribal dances by African gold miners. These miners come from their tribes in the hinterland and are under contract to work for a ten month period after which they return to their tribes. Polygamy is the standard way of living for the Bantus and they often have a city wife in the suburbs (where such wives dwell since they cannot live in the

city) plus a tribal wife who may live several hundred miles away. Marriage usually takes place only after a family has been raised in order to be certain that the wife is fertile.

We then visited Pretoria which is just about an hour's drive away. Again we had a series of lectures arranged for us. Malnutrition occurs because of the economic situation and several talks on this problem were given to us. We also heard a discussion of the pattern of tuberculosis in the South African Bantu, as well as a talk on mycotoxins and liver cancer. Our dermatologic contingent was treated to a visit to the office of one of the best known local dermatologists, Dr. Cyril Ross. Here we saw several unusual cases. Later we were dined and entertained at his home. Part of the evening there was devoted to slides showing pictures of the witch doctors. We saw the procedures that they go through, both in learning to be a witch doctor and how they treat their patients. Witch doctors are fairly conservative in the type of treatment that they render to the patients. This is essentially a suggestive or emotional approach. Strong herbs are occasionally used as part of the treatment. In rare circumstances a trephine of the skull is done but this is becoming less and less common today.

We visited some excellent museums. We learned that Pretoria has four billion dollars worth of gold stored in its vaults.

A five hour flight carried us to Nairobi, in Kenya. Here we found ourselves in fairly primitive conditions. Nairobi has a large hospital, but it is badly understaffed. Medications are at a premium. One of our lectures was on Burkitt's lymphoma which is very common in Kenya. In South Africa we felt the oppressive atmosphere of *apartheid;* in Kenya we found ourselves under a government essentially "black," though there is a carry-over of some of the whites from the previous regime and a small number of Indians. Asiatics are not welcome, although they have been told that citizenship is available to them. They must obtain this in order to remain in the country after September of 1968. Those filing for it say that it is difficult for an Asiatic to get citizenship. Since most of these "Indians" have a British passport they are further confronted with the fact that Britain will not allow them to leave Kenya for the British Isles. Our world is a difficult place in which to live and work.

Later, we transferred to one of the most luxurious resorts in Africa; the Mt. Kenya Safari Club. We stayed here for a number of days just resting. A small golf course was available as well as horseback riding and fishing. We played with a view of Mt. Kenya. This is always covered with snow.

Johannesburg and Nairobi are both about 5,000 feet above sea level so that we found ourselves in comfortable and pretty much insect-free locations most of the time. At Nanyuki (just a few miles from the Mt. Kenya Safari Club) we had an opportunity to see a 30-bed hospital. There was only one physician. He told me that the out-patient clinic averaged about 300 patients a day and in addition he had his hospital work to do. Prior to his service at Nanyuki, there had been no doctor present for some period of time other than the services rendered by a medical assistant. We spent the next four days at four different, but always exotic, lodges. One was the famous Tree Tops Hotel built forty feet above ground in the branches of several cape chestnut trees. Here the night is spent watching elephant, rhinoceros, buffalo, and other animals as they come to visit the watering hole which is also the site of an old salt lick. The salt lick is spiked by the Tree Tops personnel who add twenty-five pounds of salt every night, further to encourage the animals to come. Another important addition is an artificial moon, one at each corner of the hotel. So with four moons present, it is easy to see the animals. It is also easier for the animals to find the watering hole. One unusual sight is to see the elephants bury their tusks into the ground for a foot or two and use it as a shovel to turn the earth up so that they could then pick or chose tidbits containing the salt and minerals they craved. When I first saw them feeding in this

way I noticed them coiling their trunk up on the ground. Do you know why? As they dug their tusks into the ground, the trunk automatically was coiled up neatly to avoid spreading it out over the ground for several feet. Goodluck bracelets, by the way, are made from the tuft of long hairs present on the ends of the elephants' tails.

It was interesting to see the calves nursing the anterior nipples on the mother's underside almost between the front legs. This gives the mother an opportunity to protect the babies from an attack by leopards and lions and (in India) by tigers. The death rate of calves is high. Even with the lion cubs where there are few natural enemies, only about 25 per cent of the lion cubs grow to maturity.

The following day we flew by small plane to Samburu in the Uaso Nyiro game reserve in Tanzania. Here we lived in large thatched roof cottages arranged for only two people per cottage. The beds were protected by mosquito netting which I had never seen before. These are hung from the ceiling and draped around the edges of the bed so that it looks like a cheesecloth tepee. Here, we were introduced to early morning tea and the awakening knock. A bush clinic at Samburu was held and all of us pitched in to give the patients a type of first aid care under primitive conditions and with limited amounts of drugs. *Moja kela seku?* Oh yes, means one a day!

We saw interesting game at Samburu. The following day was spent in more primitive surroundings in the Seranera Lodge on the edge of the Serengeti Park. These were somewhat primitive lodges in the sense that we lived in tents (which by the way were so arranged that you were completely zipped in at night to protect against prowling game). It still had plenty of modern conveniences including a shower which ran overhead from a canvas bag, and unusually good food and lots of fruit. Here we saw the migrations of hundreds of thousands of zebra which covered the plains as far as we could see. These are similar to the enormous buffalo migrations that occurred in our country in the past century.

The following day we flew to Lake Manyara Hotel. This large and handsome hostelry is built on the extreme end of Great Rift Valley. It commands superb views over the Lake Manyara Park. We saw elephants and rhinoceros and we even saw a type of lion which perches in trees—an unusual attraction here. The following day we flew to Tsavo Park. Kilaguni Lodge is a lovely building with a large veranda on which all the meals were served. It looked over a fairly large plain also with artificial moons which animals visited and could be viewed. We were taken to a scenic natural spring and pool. Here we saw hippopatamuses for the first time on our trip and also crocodiles. Fishing was prohibited so that the crocodiles would be assured of an ample food supply.

At 6:30 A.M. we flew in to Nairobi airport from the Kilaguni Lodge. We flew past Mt. Kilimanjaro, the highest peak in Africa. The airport was closed in by fog and after circling in the air for about one half hour we felt ourselves fortunate in making a landing in time to meet our connecting plane to New York. This took twenty hours of flying time.

The average age of the doctors on our trip probably was close to sixty and I was amazed at the stamina in this age group. These trips are exhausting but worth while. My parting word of advice is try to get your travel agent to arrange to keep you pleasantly occupied but not overly busy, and to arrange flights in such a way that there is opportunity to get sufficient rest so that you can enjoy the opportunities made available to you.

7 Watchung Avenue

LSD has produced some beneficial effects in alcoholics and sociopaths—not reliably so, but enough to warrant further research.

Clinical And Experimental Aspects Of Psychedelic Drugs*

Thomas E. Shoemaker, M.D./Belle Mead

"Psychedelic drugs finally give the tool to self-understanding and cure of most mental illness." "Psychedelic drugs are extremely dangerous and should never be used." Most of us have heard both statements, though perhaps not in just those words.

Let us here review some of the clinical work done with psychedelic drugs and some of the experimental possibilities. Perhaps we can then evaluate more realistically than either of the first statements what the current and possible future medical role of these drugs should be.

I will confine my comments to D-Lysergic Acid Diethylamide called "LSD" since this is the only psychedelic drug which has been used to any degree clinically. Some studies have been done with mescaline, psilocybin, and other similar compounds. LSD was first synthesized in Sandoz Laboratories in Switzerland in 1938 as an oxytocic to promote uterine contraction. Since it was not an especially active oxytocic, it was put aside.

In 1943, Hoffman was working in the laboratory and accidentally ingested some LSD. On the way home he began to hallucinate and ran his bicycle into a tree. He discussed this with some of his colleagues and they tied this experience to the drug and so discovered the hallucinogenic properties of LSD.

As this was further studied, it was felt that LSD would be an ideal tool to produce an experimental schizophrenia which would make it possible to understand this disease better. But it soon became apparent that the psychotic reaction with LSD was *not* like schizophrenia. The drug was then tried by many investigators in all sorts of psychiatric disorders with varying results, but most of them encouraging. Many investigators feel that the investigator himself should have a personal experience with LSD. The question is, after taking the drug, "Is one an objective observer or a convert?" I have taken it, so perhaps I should not judge. I agree that it is important for the investigator to have had experience with the drug. Two main methods of use have been described: (1) As an adjunct to psychotherapy and (2) As a psychedelic experience.

As an adjunct to *psychotherapy*, doses of about 50 micrograms are given and the patient is seen in regular psychotherapeutic interview. It is said that this heightens sensitivity and enables the patient to experience more *feeling* in relationship to uncovered material. Numerous reports assert that this is beneficial. The drug has also been used in a similar way in group therapy. The use of the drug as a psychedelic *experience* (first described by Osmond in 1957) is ac-

*Read before the Section on Psychiatry and Neurology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

complished by giving one large dose of from 250 to 1800 micrograms which produces an hallucinatory experience lasting about six to eight hours. The experience varies with the individual and may be exquisitely pleasant or rather terrifying, or some of each. The experience in any case is a profound one. Why such an overwhelming experience should have a therapeutic effect is not really understood, but certainly in some cases this has been true.

My own personal experience in treating patients has been with the one large dose with a psychedelic experience. In this work at the Carrier Clinic, patients were thoroughly studied physically, were seen in psychiatric evaluation by at least two members of the staff and were given a complete battery of psychological tests. Any patient considered potentially schizophrenic or suicidal was not considered for treatment. A patient chosen for treatment was taken to the treatment unit which is in a separate building, sufficiently distant from other hospital buildings, to be quiet. The patient remained in bed in a darkened room with soft background music. A nurse and physician were in constant attendance. The patient was allowed to talk if he chose to, but was neither encouraged nor discouraged. Records were kept of anything the patient said. Most patients had little to say during the experience, except perhaps to ask for food or water. The reaction usually lasted six to eight hours. Following this, the patient was given dinner and allowed to sleep overnight in the treatment unit with a nurse in constant attendance. Sodium amobarbital (Amytal®) was given routinely for sleep the night following the treatment and usually 9 grains was the dose. The day following the treatment, the therapist would discuss the patient's experience with him.

In our experience, the highest ratio of improvement was found in alcoholics. This is also reported by others. We found about 50 per cent of alcoholics were dry or (perhaps what is more interesting) that some had turned to social drinking without abuse.

Of considerable significance was our experience with obsessive-compulsives and sociopaths. The proportion of improvement in both groups was very small; but the ones who had a response, showed a remarkable one. One patient, who was crippled with obsessive-compulsive symptoms, was completely free of symptoms after one treatment and was well on a two year follow up. One sociopath who had taken narcotics, been arrested for stealing, had been expelled from school, and had impregnated the neighbor's daughter responded to one treatment and after discharge from the hospital, returned to private school where he was a model student, president of the student council, and captain of the football team. Since these are two illnesses which are difficult to treat, I feel it is one area where LSD should be considered presently for use.

Should the investigator have personal experience with the drug? I feel that it is useful to have the experience, especially if prescribing large doses of the drug, since there are certain aspects of the reaction common to most persons who take large doses. The therapist is therefore better able to understand these and to handle them.

Reactions in most individuals on large doses are: (1) Distortion of time perception, (2) Distortion of body image, (3) Paranoid thinking or tendencies in response to outside stimulus. These occur to nearly all users to a greater or lesser degree, but it is important for the therapist to be familiar with them in order to avoid as much as possible a disturbing experience for the patient. Under large doses, patients may misinterpret the simplest comments or even movements. In my own experience, under the drug at one point, I asked the physician with me how my wife was. His response was, "We have called her," intending to reassure me. I had lost all sense of time and thought she had been called because it was several weeks later and I was still psychotic. We had one patient who commented about a picture in the room. The therapist began to question the patient and he became extremely paranoid and hostile.

Because of the kind of reaction, communication with the patient should be kept to a minimum and be in the simplest, most reassuring terms.

In the foregoing, we have been looking at the possible benefits of LSD. We must certainly look at the other side. Most physicians are aware of the increased number of patients (especially younger people) being admitted to psychiatric hospitals because of adverse LSD reactions. This is a powerful and dangerous drug out of medical hands, because everyone who takes a large enough dose becomes temporarily psychotic; and those who are potentially psychotic may remain so.

There are records of suicide and murder under the effect of the drug in people who apparently did not remain psychotic after the trip. One reason for the increased illicit use of the drug is the belief that it broadens one's thinking and intensifies the ability to experience things and perhaps to be creative. The true artist is sufficiently in touch with his unconscious to be able to be creative without such a crutch, which actually divorces his experiences from reality.

Another aspect of the drug which is equally dangerous (and perhaps more so for the future) is the chromosomal breakage which has been reported following its use. This has not only been found in users of the drug, but also in babies of mothers who have taken LSD while pregnant.

A third concern is the reported damage to the microcirculation of the brain in experimental animals. One wonders how much this may occur in man. If we look now at the clinical and experimental aspects of psychedelic drugs, it seems that LSD does have a place though limited, in the psychopharmocologic inventory for severe obsessive-compulsive reactions and for sociopaths, when all other methods have failed.

The ratio of response is not great; but when it works, it works well and should be tried as a last step. Certainly reports with alcoholics are favorable, but I feel that there are other methods less dangerous to be used with this illness.

From the experimental point of view, I feel the drug should be continued to be studied under strict control and supervision.

To summarize, I have explained briefly the discovery of LSD, the fact that it was thought to produce an experimental schizophrenia, which it did not, and then the two general methods of use. I have given a bit of my experience with the psychedelic experience technic and the kinds of patients who have shown some response to the drug. The dangers of the drug have been pointed out, and finally my own feeling about its place in psychiatric treatment and research.

Bibliography

1. Isbell Harris: Comparison of the Reactions Induced by Psilocybin and LSD—25 in Man: National Institute of Mental Health, Psychopharmacologia, I. Bank, I. Heft (1959) S.29-38

2. Sidney Malitz, M.D., Harold Esecover, M.D., Bernard Wilkens, M.D., Paul Hoch, M.D.: Some Observations on Psilocybin, A New Hallucinogen in Volunteer Subjects: *Comprehensive Psychiatry* Vol. 1, No. 1, February 1960

3. Dr. H. Leuner and Dr. H. Holfeld, Gottingen: Psychotherapy Under the Influence of Hallucinogens

4. R. N. Carrier, M. D., H. LeFever, M.D., J. L. Ward, M.D., Preliminary Report of the LSD Project at the Carrier Clinic (unpublished): Presented to the Dept. of Psychiatry of Temple Univ. School of Medicine, Phila., Pa. Feb. 1961

5. Gustav Schmiege, M.D., The Current Status of LSD as a Therapeutic Tool (a summary of the clinical literature on LSD) presented at the American Psychiatric Assn., Toronto, Canada, May 8, 1962

6. Clinical Value of LSD Questioned, Physical Damage Reported, *JAMA*, Sept. 25, 1967, Vol. 201, No. 13, p. 24

The Carrier Clinic

Here is a ready reference guide for all who work in the emergency room and have to receive the acute alcoholic.

Emergency Room Management Of The Alcoholic*

Michael Shenkman, M.D./Westwood

The alcoholic does not drink alcohol: he consumes it.
—S. H. Bacon, Ph.D.

Until it is accepted as an illness, we cannot begin to discuss the solution to the alcohol problem.
—M. A. Block, M.D.

Most medical organizations know perfectly well that alcoholism is a disease. More than that, it is a multidimensional problem with social, cultural, economic, environmental, and psychologic components. The medical profession is invested with the responsibility of treating disease — and preventing it — and therefore this is a problem for the physician.

Any person presenting himself (or herself) to the emergency room looking for help and/or advice because of a drinking problem, deserves scrupulous attention, seriousness, and a responsible approach from the physician in charge, the nurse on duty, and from all other members of the staff working in the emergency room.

Once the physician is engaged in examining him or is evaluating his drinking problem, that person becomes a patient, like any other patient afflicted by any disease.

Clues to the Diagnosis

Remember that drunkenness is not alcoholism, just as glucosuria does not mean diabetes mellitus. Define alcoholism as the use of alcohol or alcoholic beverages to the extent of causing any continuing adverse effect upon the individual or his family or community.[3]

When can we apply the disease concept to alcoholism? The answer is this — the disease concept applies when it can be described by:

1. psychologic dependence
2. loss of control
3. combination of tissue tolerance and physiologic dependence accompanied by symptoms of withdrawal

Watch for and look for clues from the history:

1. need to drink when required to make decisions, resolve conflicts, or exercise responsibility
2. frequent drinking sprees
3. steady increase in intake
4. solitary drinking
5. early morning drinking ("eye openers")
6. gulping
7. loss of control drinking
8. Monday morning absenteeism
9. blackouts
10. car accidents, frequent arrest, or trouble at home
11. frequent traumas, bruises in unusual spots
12. personality changes
13. anxiety, apprehension, depressive reaction, moodiness, remorse, or feelings of guilt
14. denial that there is a drinking problem when you, the examining physician, think there is one
15. episodes of frequent alcohol intoxication (in the beginning, during week-ends)

Look for and note clues from the examination:

1. moonlike, plethoric, round face
2. rhinophyma
3. facial telangectasis
4. tremor
5. anxiety, apprehension, or slurred speech

* This work is from the Departments of Internal Medicine at Pascack Valley Hospital and Bergen Pines Hospital. Dr. Shenkman is chairman of the Bergen County Medical Society's Committee on Alcoholism.

6. traumatized areas, ecchymosis, bruises in unusual places due to falls or hitting walls, poor hygiene, and shabbiness

Note clues in connection with medical complications due to long term drinking:

1. avitaminosis
2. malnutrition
3. dehydration
4. liver cirrhosis
5. ascites
6. peripheral neuritis and radial nerve palsy
7. encephalopathy
8. pulmonary emphysema in connection with excessive smoking
9. pulmonary tuberculosis
10. cardiovascular complications
11. urinary complications
12. gastritis
13. suicide attempts

The three serious dangers in the emergency room are coma, fractured skull or pelvis, and/or subarachnoid hemorrhages. Also, don't be misled by innocent sounding answers, such as: I drink only socially (what does he mean by "socially?") — or, I'm only a light (moderate, occasional) drinker — I drink only on weekends — I never drink on the job — I drink only to feel good — I can take it or leave it whenever I want.

Criteria for Admission of the Alcoholic

1. Acute Intoxication — admit if no adequate care at home can be provided

2. Patient in coma

3. Patient in any other acute distress and with alcohol involvement

4. Patient suspected of having any of the above enumerated complications in need of further clinical, x-ray, and laboratory studies

5. Dehydration

6. Nutritional deficiencies, if adequate care cannot be provided at home

7. Delirium tremens, alcohol encephalopathias — provided a bed and trained personnel are available

Immediate Care for Patients to be Released

Reassurance to the family members, friends, and relatives present. Have at your finger tips some solid information about community resources such as alcoholism treatment centers, clinics, social agencies, AA's Al-Anon, Al-Teen, National Council on Alcoholism Chapters, and others.

Do not forget the clergyman. Ask about his church. The pastor can provide great help to the patient as well as to the family. The pastor's attitude toward alcoholism and alcoholics has to be known to the doctor before he suggests the referral. Do you know whether there is a good relationship between the clergyman and the patient?

Sedation, if necessary, should be of short duration, and under supervision of the family physician. Beware of barbiturates. These act synergistically with alcohol as a depressant. Try analeptics, vitamins, an improved diet, and appropriate symptomatic treatment.

Get in touch with the family physician. Give him an abstract of what was done in the emergency room. Consider psychiatric consultation. Do not refer the alcoholic to AA before being sure that all medical, psychiatric, and psychologic studies were or will be done. Let the family physician, not the emergency room, make this reference.

Here are the sixteen items which must be recorded in the emergency room. Use this as a check list before you release the patient:

1. Name, address, telephone, year of birth, occupation, and religion.

2. Marital status. Note if separated or remarried. How many times?

3. Who (a) took this history, and (b) supplied the information?

4. In brief, what is the problem?

5. Does he drink alone or in groups? At taverns, bars, home, with meals, friends, coworkers, spouse, or strangers?

6. When did he have his first drink? For how long has he been an excessive drinker? How often does he drink now?

7. What beverage does he prefer? Does he sip it, gulp it, swallow it slowly?

8. Car accidents? Police arrests? Complaints from neighbors?

9. At home, does he watch TV? Read? Sleep? Drink constantly? Sexual adjustment?

10. Job history. Present and past occupations? Frequency of job turnover? Fired for drinking or absenteeism?

11. Drinking problems of father, mother, spouse, siblings?

12. What is his smoking pattern?

13. Significant items in medical history.

14. Personality — shy, aggressive, anxious, suspicious, lazy, energetic, hostile, gregarious, withdrawn, solitary, cheerful, moody, intelligent.

15. What is school or college record?

16. What was done for him in the emergency room, and if admitted, or referred elsewhere, specify?

I also suggest seminars at each hospital where this can be discussed, details worked out, and suggestions recorded. This kind of human pathology must not be swept under the rug. It is a challenge to all of us.

Bibliography

1. Fagan, Paul C., M.D.: "Recommendations to Interns and Residents re Emergency Approach to the Acute Alcoholic." The Mountainside Hospital, Montclair, New Jersey

2. Williams, Ben H., M.D.: "Accident Ward Treatment for Withdrawal." Study Clinic for Alcoholism Control, West Jersey Hospital, Camden, New Jersey

3. Block, Marvin A., M.D.: *Alcoholism — Its Facets and Phases.* New York, 1965, John Day Company. P. 320

4. Fox, Vernelle, M.D.: "Alcoholism," *Disease-a-Month,* January, 1965, P. 51

5. Rosen, Walter B., M.D.: "Could that Nice Mrs. M. be an Alcoholc?" *Medical Economics,* September, 1967

6. Shenkman, Michael, M.D.: "How To Take A History Of An Alcoholic" *The Journal, MSNJ,* 61:2:54 (1964)

199 Honeysuckle Drive

Family Specialist . . . Is He Necessary?

The American Academy of Pediatrics has questioned the practicality and necessity for developing the new family physician specialist as called for in the Millis Commission Report, which was approved by the AMA House of Delegates. The Academy has said that the educational recommendations as spelled out in the Millis Report do not "outline the background of a new specialty." They suggest that "committing educational institutions to the development of a new specialty, which in reality would be a non-specialty, is not warranted. A more fruitful approach would be to educate and orient medical students and trainees in existing specialties more effectively to understand and serve the total needs of the individual and of society." The Academy insists that the present-day pediatrician and internist "are already committed to rendering and do render" the comprehensive personal medical care called for by the Millis Commission. "The logical step toward meeting the demands of a mobile society for comprehensive medical care would be to utilize modern computer technology for the storage and release of information relevant to the provision of continuous and comprehensive care."

The Academy further points up the feasibility of group medical practice in which medical specialists within the group "may act as the primary physicians for families, utilizing the skills of the specialties within the groups, and directed by those specialists (pediatricians and internists) already oriented toward comprehensive care. "This desirable, comprehensive and continuing medical care can best be rendered by a change in the organization of medical practice into a logical and shared division of labor" the AAP concludes.

Even in the presence of ascites and edema, the doctor may need to push fluid intake. He has to avoid too serious a reduction of circulating blood volume. And here is why.

Extracardiac Complications Of Aortic Stenosis*

Sylvan E. Moolten M.D./New Brunswick

In this age of aggressive surgery even the advanced nodular calcified deformity of the aortic valve has become a meeting place for surgeon and clinician. This was made possible largely through the development of ingenious valvular prostheses. Until we are able to prevent the occurrence of aortic stenosis the hopes of the future probably lie with those who can devise the best mechanical contrivance to replace the deformed valve.

Even when we cannot give surgical help, the diagnosis of aortic stenosis must be made accurately so that appropriate medical therapy can be used and the prognosis understood. Too often the diagnosis is disclosed only at autopsy; or, conversely, the lesion, strongly suspected or diagnosed with assurance, is not found at autopsy.

The prognosis of calcific aortic stenosis is unpredictable. The most dramatic complication is, of course, sudden death. The threat of sudden death is most common in patients with aortic stenosis who are subject to sudden attacks of syncope on exertion. Sudden death may occur on the operating table in the course of some ordinary surgical procedure. Although sudden death has been reported in 19 per cent of cases[1] a wide variety of other modes of death have been reported. About a third of these patients die of congestive failure, 20 per cent of subacute bacterial endocarditis, 9 per cent of pneumonia, and a smaller proportion of myocardial infarction, pulmonary embolism, and cerebral vascular accidents.

The syndrome of effort syncope is so characteristic of aortic stenosis that one may be led to suspect its existence from the history alone.[2] Convulsions may occur with this form of syncope so that in certain cases the diagnosis actually has been idiopathic epilepsy. Certain features of the syncopal attacks suggest a relationship to myocardial ischemia, especially their precipitation by effort and relief by rest. In fact, in some cases, angina pectoris may precede the syncopal attack and is probably accounted for by reduced outflow through the narrowed aortic valve chink.

The following cases, observed recently, draw attention to the severe extracardiac complications of aortic stenosis revealed in the gastrointestinal tract and liver.

Case One

A 73 year old man had been admitted 3 years previously because of severe anemia, shortness of breath, swelling of the legs of 5 months' duration, and more recent chest pain. Examination revealed a systolic murmur at the apex, A2 louder than P2. Lungs were clear. Blood pressure was 130/70. The liver was swollen 3 finger-breadths below the costal margin. The extremities were swollen with marked edema. The clinical impression was "arteriosclerotic heart disease" with congestive failure. Hemoglobin was 5 Grams, hematocrit 20, white blood cells 5000, neutrophiles 77 per cent. Red cells exhibited marked achromia. Electrocardiogram showed findings of chronic left ventricular strain and some anoxic defect. During hospitalization he complained of severe precordial pain radiating to the back. He was given anticoagulant therapy but this was later discontinued because of the suspicion of dissecting aneurysm. Electrocardiographic signs were characteristic of myocardial infarction. The patient was given blood transfusion but on discharge hemoglobin was only 7 Grams, hematocrit

* From the Middlesex General Hospital, New Brunswick.

33.5. No explanation for his anemia was found at that time.

He returned 6 weeks later because of difficulty in breathing and chest pain radiating to the back. Hemoglobin was 11 Grams, hematocrit 33. No explanation for the anemia was detected at this time either and he was discharged to our outpatient clinic.

He was readmitted subsequently because of another attack of chest pain and right hemiparesis. The diagnosis was cerebral embolus or thrombosis following myocardial infarction. He was discharged again to the clinic. A loud systolic-diastolic murmur was now detected. He was treated with digitalis and became free of edema. He continued to complain of dyspnea and anginal pain on exertion and had several episodes of tarry stool. Following one such episode he was brought to the emergency room but was dead on arrival.

Autopsy Findings: Autopsy revealed massive hypertrophy of the left ventricle (650 Grams) secondary to aortic valvular stenosis with slight insufficiency. The coronary arteries were patent throughout and exhibited mild segmental atheromatous narrowing without occlusion. The lungs exhibited patchy interstitial fibrosis and emphysema characteristic of interstitial fibrosis observed in patients with rheumatic heart disease[3] accompanied by moderate hypertrophy of the right ventricle. Dark stool was present in the colon but no source of active bleeding was present at autopsy in the upper gastrointestinal tract. As an incidental finding, the deceased was found to have a parasagittal meningioma of the left cerebral hemisphere.

Case Two

A 50-year-old man was admitted with a history of epigastric pain of burning character related to meals and some vomiting. He was a heavy smoker and had been under treatment for bronchitis. He had had rheumatic heart disease at age 13. Recently he developed edema and some shortness of breath and was treated with digitalis. Examination showed blood pressure 100/90, pulse 90, respirations 28. A loud systolic murmur was heard over the precordium. The liver was palpable four fingerbreadths below the costal margin. The clinical impression was chronic duodenal ulcer and rheumatic valvular disease. X-ray revealed enlargement of the heart, pulmonary congestion, and some edema. Hemoglobin was 15.5, hematocrit 49, white blood cells 15,300, neutrophiles 77. Venous pressure 21 millimeters. Circulation time was 18 seconds. Following admission the patient had several hematemeses. X-ray series revealed no source of gastrointestinal bleeding. Electrocardiogram revealed "chronic myocardial damage with possibility of some anterolateral myocardial infarction." The cardiologist suggested the possibility of combined mitral and aortic disease on a rheumatic basis with aortic stenosis predominating and secondary myocardial infarction. He also suggested the possibility of chronic pulmonary disease secondary to rheumatic valvular disease complicated by severe bronchitis. The patient continued to have lower abdominal pain and then suddenly died 12 days after admission.

Autopsy Findings: The heart showed hypertrophy and weighed 530 Grams. The aortic valve orifice was narrowed by a calcific stenosis with thickening and fusion of the cusps and barely admitted the tip of one finger. The cusps were fixed and rigid. The mitral valve revealed moderate stenosis and insufficiency. The coronary arteries were slightly stippled with atheroma but not significantly narrowed. Myocardium revealed no evidence of old or recent infarction. Lungs were somewhat indurated throughout as a result of diffuse interstitial fibrosis (post-rheumatic), as revealed microscopically, together with some anthracosis and centrilobular emphysema. There was no significant edema and only moderate congestion. The liver showed intense centrilobular hemorrhagic necrosis as seen in intense shock. The pancreas also exhibited scattered foci of necrosis. The pancreatic lobules had a slightly threadbare appearance as the result of shrinkage and loss of acinar cells and some interstitial edema. The source of hematemesis was not detectable at autopsy.

Case Three

A 76-year-old man was first admitted 7 years previously with sudden onset of fainting, weakness, and collapse. This had occurred while he was mowing his lawn. He was admitted as a case of "coronary insufficiency." Blood pressure was 160/80. Pulse was slow and regular. He had an enlarged heart with mitral and aortic systolic murmurs but no thrills. He had no edema. He had moderate hypochromic anemia. Hemoglobin was 10 Grams, hematocrit 33, white blood cells 5,000; transaminase was 12 units; electrocardiogram showed evidence of left ventricular hypertrophy. His anemia responded well to treatment with iron and vitamin B-12 and he was discharged in good condition.

On a second occasion 5 months before admission, he had sudden dyspnea, orthopnea and cough. The cardiologist made a diagnosis of "old aortic stenosis with secondary left ventricular hypertrophy." The heart was markedly enlarged and a Grade IV ejection type of systolic murmur was present. The murmur was heard best at the aortic area and transmitted downward toward the apex. He was given digitalis and discharged.

On his last admission he complained of weakness, nausea, weight loss, and increasing shortness of breath but no chest pain. Heart tones were strong and irregular; the rhythm was totally irregular. A loud systolic murmur was heard at the base and transmitted to the apex. The liver was felt 4 to 5 centimeters below the costal margin. Blood pressure was 130/70. Impression was aortic stenosis with auricular fibrillation and arteriosclerotic heart disease. The anemia could not be explained. Chest x-rays showed enlarged heart and findings interpreted as pulmonary congestion. Transaminase was 550 units; carbon dioxide was 40 volumes per cent; sodium 139, potassium 6.8, chlorides 107; Blood urea nitrogen 120 mg. per cent, icterus index 22; bilirubin 3.4 milligrams per cent; direct bilirubin 1.9 mg. per cent. Hemoglobin 15.5, white blood cells 13,800, neutrophiles 85, hematocrit 48.5. His urine contained two-plus protein, no sugar or acetone, myriads of granular and hyaline casts, and a few red blood cells and white blood cells, the specific gravity was 1.015. His condition grew progressively worse and he developed signs of cerebral anoxia. His severe azotemia, jaundice, and terminal coma were all attributed to poor cardiac output.

Autopsy Findings: The heart weighed 650 Grams as a result of massive hypertrophy of the left ventricle associated with old calcific aortic stenosis, the orifice admitting only the tip of the finger. The right ventricle was also considerably hypertrophied, measuring 6 millimeters in thickness (about twice normal thickness). Mild, irregular, postrheumatic scarring was present in the mitral valve. The coronary arteries were moderately narrowed by atherosclerosis.

The lungs were congested, somewhat edematous, and rather rubbery in consistence. Microscopically, lung tissue exhibited disseminated interstitial fibrosis of alveoli with areas showing cuboidal epithelial metaplasia of the alveolar epithelium, mild perivascular and peribronchial fibrosis, a few patches of carnifying pneumonia, and scattered dense subpleural scars. The bronchi were chronically inflamed and exhibited mucous cell hyperplasia. Multiple small emboli were present in small arteries.

The liver was reduced in size, weighing 1250 Grams, and exhibited extreme centrilobular congestion. Microscopically advanced centrilobular necrosis was found. About two thirds of the hepatic substance had undergone necrosis. Much resorption of the necrotic liver tissue had resulted in secondary collapse of sinusoids and varying degrees of hemorrhage. For the most part the remaining sinusoids were empty of blood but the reticulated pattern of the lobular framework gave striking evidence of previous intense sinusoidal congestion during life.

The kidneys were grossly normal except for a few patches of partly hemorrhagic, partly ischemic early necrosis. These patches were indefinitely demarcated. Microscopically, these corresponded to areas of acute anemic infarction with minimal reactive inflammation. The glomeruli in these areas were filled with fibrin. The periprostatic venous plexus was extensively thrombosed.

The brain exhibited minor degenerative changes throughout the cortex and cerebellum and some brain stem edema.

The bizarre clinical manifestations of aortic stenosis depend largely on the hemodynamics of the circulation in the presence of the stenotic valve orifice. Classically the clinical picture is that of an adult male, often well on in years, who develops slow but progressive cardiac decompensation. Examination reveals a systolic thrill and harsh loud systolic murmur over the cardiac base with or without a diastolic murmur. The pulse is often characteristic — normal or decreased pulse pressure, anacrotic pulse tracing ("pulsus parvus, rarus, tardus"). There is enlargement of the heart, a history of rheumatism early in life, and a history of recurrent dizziness or syncope. One point which is often overlooked is that all the usual signs of an aortic lesion may be lacking when cardiac contraction is impaired in the presence of heart failure.

The pathogenesis of calcific aortic stenosis is based largely on mechanical factors. The sex ratio is 4 to 1 in favor of males, presumably because of the normally more forcible systolic ejection flow in the male ventricle compared with the female. Once the aortic valve cusps become thickened by even mild rheumatic endocarditis, they are unable to yield readily to the systolic jet. As a result, the original inflammatory thickening is progressively magnified by the purely mechanical stress of the force of ventricular ejection. Continued progression of such tension sclerosis with secondary calcification increases the resistance to outflow and therefore induces compensatory ventricular hypertrophy. A vicious cycle results in which the progressive increase in force of the ejection thrust is countered by an equally active progression of tension sclerosis. Eventually the ventricle becomes fatigued and heart failure or other complications ensue. Surprisingly certain patients with this lesion may reach an advanced age, even the 8th or 9th decade, and present at autopsy massive hypertrophy of the left ventricle and a narrowed chink of valve orifice which can be barely pried open with a chisel. Except for the coexistence of residua of ancient rheumatic sclerosis of the mitral valve, one might have difficulty in assigning the origin of the aortic lesion to an early rheumatic lesion in childhood. Other causes of the same lesion are less common. These include congenital bicuspid valve, the special type of valvulitis accompanying rheumatoid arthritis of the spine, familial xanthomatosis, brucellosis, ochronosis, and certain other conditions.

According to my experience a variety of associated findings are often observed in patients with aortic stenosis which are attributable largely to diminished cardiac output. Quite frequently the clinical picture is that of unexplained gastrointestinal hemorrhage as in Case 1 and Case 2. Generally autopsy discloses erosions of the duodenum similar to those found in severe shock or "forward failure." The lower esophagus in one case seen by the writer was the seat of extensive erosive esophagitis and the stomach displayed 3 shallow ulcerations with recent hemorrhage. Gastrointestinal bleeding has been commented on by a number of writers. In one series of gastrointestinal bleeds, aortic stenosis accounted for bleeding in 5 per cent (Williams[4]).

Another common finding in my personal series

of autopsies, including the cases described above, has been extreme centrilobular necrosis of the liver, which is also attributable to diminished cardiac output ("forward failure"). This is reflected clinically by the development of jaundice and cyanosis. In such patients autopsy has revealed advanced cardiac cirrhosis as well as extreme centrilobular necrosis of the liver, both old and recent. Focal necroses have also been found in the pancreas and spleen. In Case 3, and in another case with extreme centrilobular hepatic necrosis, massive necrosis was also found in the kidneys resulting in uremia.

Although congestive heart failure is a common finding in aortic stenosis its mechanism is not always easily ascertainable. Obviously the failing left ventricle can itself be the basic cause, especially if it undergoes recurrent attacks of ischemic injury as a result of reduced flow in the coronary system. The findings therefore often mimic those of primary coronary arterial disease even though the lesions of the coronary arteries themselves may be relatively mild.

In one case, seen by the writer, the heart muscle exhibited numerous minute patchy fibroses and recent necroses superimposed on extreme hypertrophy. Aging itself becomes an important factor in myocardial weakness when patients live to the eighth decade of life or longer. In other instances the heart failure can be shown to result primarily from increasing strain on the right ventricle as a result of interstitial fibrosis of the lung secondary to rheumatic pneumonia which was part of the original rheumatic fever.[3]

The unique hemodynamic problems of calcific aortic stenosis invite special consideration in medical treatment. When heart failure occurs in such patients the physician is confronted with a dilemma. He must decide whether to treat the patient with diuretics and low salt intake in order to overcome edema and pulmonary congestion. At the same time he must avoid reducing circulating blood volume to the point of further reduction of cardiac output. I have recommended departure from customary methods of treatment in such cases in favor of a more liberal attitude about fluids. Opportunity to test this principle arose in a case of aortic stenosis treated by me 13 years ago. The patient in question had become completely refractory to mercurial diuretics and was in advanced congestive failure with massive anasarca when first seen by me. His chief complaint was profound weakness and syncopal attacks complicated by anginal pain and numbness in the hand. Myocardial failure in this patient was interpreted as the result of relative coronary insufficiency secondary to reduced blood volume brought about by previous energetic treatment with a salt-depleting regime. He was therefore provided with a liberal intake of *salt and water*. Large doses of vitamin B complex and crude liver extract were given parenterally together with a high protein intake in the diet. His strength began to improve considerably. He regained his appetite and became entirely free of syncope and anginal pain. Needless to say, he gained considerable weight as a result of return of edema, which now became massive despite his feeling of well being. His weight, normally about 165, rose to 205. Elastic bandages were applied to prevent orthostatic hypotension. Nevertheless his cardiac function improved steadily and in three weeks he was able to walk about almost free of dyspnea. Subsequently his weight dropped to 173 as the result of spontaneous marked diuresis despite continued liberal intake of salt and water. Eventually he was able to resume ordinary activities, including walking up and down stairs and return to occupation. Unhappily an attack of diarrhea during the following summer precipitated heart failure once more and death occurred before adequate treatment could be given.

It would seem desirable to re-examine the validity of the principle that treatment of aortic stenosis should be based primarily on attempts to reduce blood volume by strenuous efforts to produce diuresis in order to overcome edema. The timely use of blood volume expanders and, if necessary, transfusion may in fact be the preferred approach.

This should be guided of course by whatever technics are available for measuring blood volume, including isotope surveys, venous pressure measurements, cardiac output, and the clinical response of the patient.

Summary

Calcific aortic stenosis probably has its origin in early life but progresses so slowly that many patients survive to an advanced age. Adaptation to the mechanical obstacle to outflow is made possible by hypertrophy of the left ventricle, which may reach massive proportions. Impairment in the contractile force of the left ventricle, even of relatively minor degree, may nevertheless have profound hemodynamic effects. Sudden death, presumably from acute coronary insufficiency causing cardiac standstill, is a well known manifestation of the precarious balance between effective ventricular contraction and the throttling effect of the valvular stenosis. Much more commonly the effects are transient and without lasting injury of tissues. The nervous system records such transient effects sensitively as syncope on effort, transient cerebral ischemic episodes, or convulsions.

Lasting ischemic injury is less often apparent clinically yet may contribute importantly to the patient's disability. Ischemic erosions of the esophagus, stomach, and duodenum are common and produce massive hemorrhage. Ischemic necroses of the myocardium may precipitate transient heart failure and the resulting drop in stroke volume may multiply the myocardial injury so that heart failure persists and progresses. A type of chronic or recurrent cardiogenic shock may follow manifesting itself in jaundice by reason of extreme degrees of centrilobular necrosis of the liver and in azotemia reflecting reduced renal blood flow aggravated by multiple ischemic necroses of the kidneys. This chain of events may be provoked by hemorrhage, dehydration, unusual physical exertion, or other factors which impair the ability of the heart to satisfy increased output demand.

The lessons of the autopsy in cases of calcific aortic stenosis bring home the need for extreme caution in treating patients with this disorder by standard methods, particularly overzealous diuretic and salt-depleting therapies which tend to lower the effective blood volume.

Despite departure from traditional practice, a more liberal attitude about fluid intake, even in the presence of a considerable degree of edema and ascites, and possibly the use of blood volume expanders may warrant consideration in the treatment of patients of aortic stenosis.

Bibliography

1. Mitchell, A. M., *et al.*: *Am. Heart J.*, 48:684 (November 1954)

2. Hammarsten, J. F.: *Arch. Int. Med.*, 87:274 (February 1951)

3. Moolten, S. E.: *Am. J. Med.*, 33:421 (Sept. 1962)

4. Williams, R. C.: *Arch. Int. Med.*, 108:859 (December 1961)

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Carcinoid tumors of the small intestine are rare, and hemorrhage from them, even rarer. Here is a successful case report.

Hemorrhage From Carcinoid Tumor Of The Ileum

Stanley Edeiken, M.D./Asbury Park

Carcinoid tumors of the small intestine are rare and occur in some 25 per cent of small intestinal tumors.[1] The signs and symptoms are usually caused by obstruction and/or intussusception; by the dramatic carcinoid syndrome. It is rare for the tumor to cause gastro-intestinal hemorrhage, but there have been a few case reports.[2]

This is a case report of massive intestinal hemorrhage caused by a carcinoid tumor with metastasis.

A 60 year-old male was admitted to Monmouth Medical Center complaining of vomiting of non-bloody material and syncope after passing a tarry stool two days prior to admission. The day before admission, he fainted again after passing another bloody stool. His past medical history was negative except for constipation and chronic asthma.

The patient was asthenic. Blood pressure was 100/60. Pulse was 92. The mucous membranes were pale. He had expiratory wheezes consistent with asthma. Abdominal examination was negative for mass or tenderness. Peristalsis was normal. Rectal examination revealed dark red blood on the examining glove.

Hemoglobin was 8.4 Grams per cent. During the ensuing 48 hours, the patient received six pints of blood. During this time, his blood pressure varied from 100 to 126 systolic and 60 to 80 diastolic. Hemoglobin varied between 7.8 and 8.7 Grams per cent.

He passed three dark bloody stools. Diagnosis of continuing gastro-intestinal hemorrhage from the small intestine or colon was made and a laparotomy was done. There was blood in the distal ileum and entire colon. Two feet from the ileocecal valve was an intraluminal tumor, two centimeters in diameter. This caused puckering and scarring of the serosa where it was attached near the mesentery. There were yellow-white nodules, 2 to 4 millimeters in diameter, in the mesentery. The liver appeared to be normal and did not contain any obvious tumors. Stomach and duodenum were normal.

A limited resection of the tumor-bearing ileum and an end-to-end ileo-ileostomy were done without complication.

Histological examination of the specimen revealed a carcinoid tumor with metastasis to the mesentery and to two of the lymph nodes which were resected with the specimen. Serum serotonin was negative and urinary 5-hydroxy-indole acetic acid was within normal limits.

Six months later, emergency left inguinal herniorrhaphy was done for a strangulated hernia. There was clear yellow peritoneal fluid at the time and there were several small nodules in the hernial sac. Examination of the small intestine, including the previous anastomosis, was normal except for dilatation due to obstruction. The base of the mesentery could not be examined. Microscopic examination of the nodules in the hernial sac revealed several serosal cysts.

Follow-up, four years after the original operation for a carcinoid tumor of the small intestine, revealed that the patient continues to do well in spite of proved metastasis.

A patient with invasive metastatic carcinoid tumor of the ileum is presented. The presenting symptoms consisted of those attributed to massive gastro-intestinal bleeding which continued. This made laparotomy mandatory. The tumor was found to be beyond the scope of surgical cure and therefore "palliative resection" was performed to control the hemorrhage. The patient is living and well four years following the original surgery. There is no evidence of the carcinoid syndrome.

Bibliography

1. Botsford, T. W. *et al.*: *American Journal of Surgery,* 103:358 (March 1962)

2. Southam, J.: *British Journal of Surgery,* 50:393 (April 1963); and Burnett, T. and Hartigan, J.: *Nebraska Medical Journal,* 45:355 (February 1960); and Loebel, A. S. *et al.*: *Gastroenterology,* 47:421 (May 1964); and Mann, L. S. and Simpson, R. D.: *Archives of Surgery,* 75:161 (August 1957); and Schwartz, G. S.: *American Journal of Surgery,* 11:553 (June 1966)

601 Grand Avenue

Coronary care units seem to be mostly at home in large university medical centers . . . but what about the community hospital? Here are some suggestons.

Coronary Care In The Community Hospital In New Jersey*

Results, Problems And Prospects As Of 1968

Results Of Survey—
Theodore H. Goldberg, M.D.

Today, there are at least 32 coronary care units actively functioning in our state. In response to a questionnaire sent to 67 hospitals throughout New Jersey early in 1968, there were 35 responses. Of these, 27 indicated that coronary care units were in operation, and five indicated that units were under construction. The organization, and effectiveness of these units varies considerably, and is to a great extent determined by local problems and policies. Only seven out of the 27 functioning units indicated that they limited admissions to suspected coronary occlusion or known coronary occlusion. In other words, these were the only units that functioned strictly as coronary care units. The remaining units admitted other types of cardiac problems. In four, the "other" problems included only serious arrhythmias. In sixteen, both arrhythmias and other forms of seriously ill cardiacs were admitted, as well as coronaries and suspected coronaries. This would indicate, that in most New Jersey units, the policy is to have them serve as intensive cardiac care units, rather than strictly coronary care units.

In many, if not most, of the hospitals throughout our state, there is little or no house staff. However, a few large hospitals *do* have house staffs. They are faced with the decision of just how much involvement there should be for the house staff in the unit. Fifteen hospitals indicated that the house staff was responsible for major therapeutic decisions. Of these, all but two were 385 beds or over. Twelve hospitals, including three over 385 beds, with house staffs, indicated that they had a lesser degree of responsibility and were not involved in major therapeutic decisions. In other words, although most of the hospitals that do not involve house staff simply do not have them available, some hospitals make it a policy (even though they do have house staff available) not to involve them in a decision making role in the unit.

Training of the nurse and the role of the nurse in the unit are of primary importance. Twenty-four out of the 27 hospitals with functioning units that responded to the questionnaire indicated that they have their own training programs. Only three did not.

* Presented before the sections on Cardiovascular Diseases and Medicine, Annual Meeting, The Medical Society of New Jersey, May 21, 1968. This symposium was co-sponsored by the Bergen County Heart Association.

Participants in the symposium: Theodore H. Goldberg, M.D., Chairman of Section on Cardiovascular Diseases, 1967-68, and Director of Coronary Care Unit, Pascack Valley Hospital; Dr. George T. Hare, Assistant Physician at the Cooper Hospital, and Instructor in Medicine at Jefferson Medical College; Carol P. Germain, R.N., M.S., Instructor at Rutgers-The State University, College of Nursing, University Extension Division; Dr. Jerome Goldfischer, Assistant Attending In Medicine, Englewood Hospital, and Instructor, Albert Einstein College of Medicine; Dr. Milton Wiener, Attending Physician, Hackensack Hospital; and Dr. John T. Kimball, Jr., Associate Director of Coronary Care Unit, New York Hospital, Cornell Medical Center.

Eighteen hospitals said that they sent nurses for training in other hospitals. Of these, five sent them only for initial training, while the others continued to use both local and regional training programs. All units indicated that the nurses were given the responsibility of diagnosing arrhythmias. Twenty out of the 27 allowed the nurses to give intravenous medications under specified conditions, while seven forbade them to do so. Twenty-three permitted the nurses to defibrillate, while four did not permit them to do so.

Included in the questionnaire was a request for statistical evaluation of results. It soon became obvious that the criteria for diagnosis and the method of keeping statistics (especially relating to the immediate cause of death) varied markedly from one unit to another. This made the information obtained not reliable enough for comparison.

Role Of House Staff In The Large Hospital—George T. Hare, M.D.

The formation of coronary care units has provided us with a means of reducing the mortality and morbidity from coronary artery disease, specifically myocardial infarction. However, these have placed an added burden and responsibility on the attending physician, house staff, and nursing personnel. In a unit of this type it is easy to think of the nursing personnel as the first line of defense, since they are immediately available when a cardiac arrest occurs and the need for resuscitation arises. The purpose, however, of a coronary care unit is the prevention of the complications that have given myocardial infarction such a high mortality rate.

The patient in cardiogenic shock, or in ventricular arrhythmia at the time of admission, has an extremely high mortality rate. However, it is the so-called "good risk" patient with whom we are concerned. When the "good risk" patient develops ventricular premature beats, paroxysms of ventricular tachycardia, or a bradyarrhythmia, immediate steps should be taken in order to prevent the necessity for resuscitation. In this area, an increasing burden of responsibility falls on the attending physician and the house staff. The attending physician cannot be with his patient at all times (or even be available within a minute or two); we must rely upon our house staff to give aggressive treatment to patients with precatastrophic arrhythmias. This is the initial role of the house staff in a coronary care unit. This is especially true since the nursing personnel is restricted as to the type of procedures and drug therapy they are permitted to render. The house staff physician forms the link between the nurse who cannot prescribe treatment, and the attending physician who is not immediately available. The house staff physician must be relied upon to prescribe therapy as indicated (drugs or electrical and mechanical assistance). To fulfill this responsibility, the house staff must be trained in the pathophysiology of myocardial infarction, the possible complications and their significance, and the therapy available for their treatment. In addition, the house staff must be familiar with all of the equipment in the unit and how it is used.

Our hospital has recently formed a twenty-five bed coronary care unit. This is divided into a four-bed monitor unit (which we are increasing to six beds), an intensive care section of eight beds, and a general care unit. The unit is governed by a coronary care committee of five internists, two of whom are senior advisors. The manner in which a unit is supervised and the type of coverage provided, will depend on the size of the unit and the type of institution. The three internists in charge of the unit provide overall coverage from the attending staff level. We felt that the only way in which a coronary care unit of this size could successfully function was to have the house staff take an active part in the care of the patients in this unit. At present, we use the following method for the optimal care of our patients utilizing the house staff. The senior medical resident is on call to the unit at all times, and in his absence the medical resident is on call. The intern staff is rotated through the unit to provide further coverage. This intern rotation offers an excellent means for medical teach-

ing, which is the coronary care unit's second function. In addition, the intern staff, while on the private medical service, has been assigned to physicians admitting patients to the coronary care unit. This has provided a means for training interns on an individual basis. It has also increased the amount of coverage for the unit. There are, therefore, at least two house staff physicians on call to the unit at all times. We have, in addition, a cardiopulmonary resuscitation team which responds to emergency calls from the coronary care unit, as well as the general hospital.

If a community hospital has a large house staff, the role of the house physician could be made greater and the coverage more complete by having a resident physician, and perhaps even an intern, in the unit at all times. Since this has not been possible in our hospital, we have the house staff actively function in our unit as above described. It is going to be extremely necessary to have formal and informal conferences about the coronary care unit, from a problem case standpoint, and also to deal with the newer advances in therapy. The education of both house attending and house staff must not be forgotten and it must be a continuous one. The house staff in a large community hospital must take an active part in a unit such as this, if it is to function efficiently and if we are to reduce mortality from myocardial infarction. The role of the house physician must be twofold. On one hand, the house staff provides *coverage* for the unit, a service to the hospital, and more importantly to the patient. On the other hand (and just as important), the house staff must gain knowledge and education from this experience with such a unit.

How Much Responsibility For The Nurse?—Mrs. Carol P. Germain, R.N.

Since teamwork is essential to the success of coronary care units, I have elected to use the short time allotted to focus on some determinants of professional nurse responsibility as well as on several problem areas, involving primarily the physician-nurse relationship. These have been identified as general themes in my personal contact with over 200 nurses involved in coronary care, and from direct observation in many units in New Jersey and other states.

Nursing is a profession with the focus on the patient. Physicians and nurses should discuss the needs of the patient and family and how these can best be met in a collaborative interdisciplinary effort. Nursing, like other professions, determines the limits of its own practice within the context of the law and new scientific advances, and plans the education of its own practitioners. A nurse, by basic preparation, competence, or legal license, is neither a junior physician nor pseudo-medical expert.

The carrying out of medical orders (important as this is to the specific health problem of the patient) is *not* the only work of the nurse. Other segments of nursing requiring specific knowledge and skill include continuous observation of patients, the development of interpersonal relationships which are therapeutic, prevention of complications, direct physical ministration, development of nursing care plans which provide for individualization and continuity of care with progression toward rehabilitation, provision of emotional support, and teaching for patients and their families, collaboration with other health disciplines for meeting specific patient needs, nursing research, as well as other staff development, leadership, and management functions. The need for many of these aspects is heightened when the patient is critically ill.

Some physicians label unit nurses "cardiac nurse specialists" because of their efficiency in arrhythmia detection, treatment, and resuscitative efforts. This kind of labeling should be abandoned. It is the prerogative of each profession to determine for its own members what specialist qualifications are and who meets them. Labeling of this kind identifies nursing care with meeting certain organ needs rather than meeting total patient needs to the extent possible.

Many coronary patients, especially those in the older age group, have co-existing conditions such as sensory deprivations or orthopedic disabilities, which, though not critical, demand nursing attention during the early days of myocardial infarction. They can cause physical and mental discomfort and their neglect can prolong convalescence, or worse, can produce the paradox of a healed heart in an otherwise broken down patient. Unit nurses and physicians need to recognize that the acute phase of myocardial infarction, dramatic as it is, is not the whole disease and that assisting the patient with successful integration of the illness event into his life should be viewed as an obligation from the beginning of his care.

Moving on then, from these basic premises, the following problems which have occurred in many units are presented with the hope that they can be prevented in new units and resolved in existing ones.

First, there is often lack of opportunity for the unit nurse, particularly that very important person, the head nurse, to be involved in planning the unit and in determining, evaluating, and changing policies. Often units are constructed and furnished, and then preparation of the nursing staff is relegated to a frantic, last minute venture.

Second, disturbed physician-nurse relationships develop because nurses do not automatically accept medical activities which the physician wishes to delegate. Nursing personnel, in their reluctance to assume new responsibilities, are not primarily motivated by fear of a legal suit, but rather are concerned that patients receive competent care, as the law seeks to insure. Nurses have the basic right, as well as the responsibility, to object to new roles without the necessary knowledge and supervised experience which promotes competency.

A *third* problem is the lack of preparation in new areas of treatment on the part of some physicians who admit patients. Many doctors have pushed for nurse preparation and in some cases exert a degree of control over what nurses can work in the unit. But there is not always a parallel effort to insist upon standards of physician preparation. This seems left to the initiative of the individual physician. Day[1] writes that physicians who do not fully comprehend the problems of arrhythmias and their treatment, the complexities of ventricular failure, as well as medical electronics aspects of defibrillation, cardioversion, and pacing should be required to refer their patients during the acute state of illness. It is really no professional compliment that nurses are now said to be capable of teaching physicians all they need to know about arrhythmias. It illustrates only that in this instance continuing medical education was somewhat poorer than continuing nursing education. This does not negate the value of physicians and nurses learning from each other. It only implies that the core of basic material should be a planned educational endeavor. The cost of learning by experience only can be disastrously high and patients need to be safeguarded. It is also an unwarranted drain on a nurse's emotional and time resources to have to play the traditional doctor-nurse communications game when she is concerned with a number of critically ill patients.[2]

Another area of concern is that of standing orders. Some are convenient for the physician for they save his writing out in longhand certain "routines" of care. I use the word "routines" in quotes because as one surveys the broad field of controversies in coronary care and of the wide variations of individual patient response, one can honestly ask, "What is routine?" Standing orders, though affording some guidelines for action until the physician arrives, carry a risk. For instance, in a unit I visited recently a physician called to admit a patient with acute myocardial infarction and gave as his orders, "Do what you do for everybody else."

Another problem is emergency therapy. Some coronary care unit policies do not permit

nurses to defibrillate. At least one of these units has no house staff and requires that physicians come in from home to defibrillate. There are also differences of medical opinion about the use of Lidocaine.® Policies regarding emergency measures are best determined and spelled out specifically by each institution's administrative officers, legal counsel, physicians, and nurses, considering their own resources, as well as the recommendations contained in the *Proceedings of the National Conference on Coronary Care Units.*[3]

It is not sound reasoning, in my opinion, to hand over what is medical center doctor care to a suburban or rural hospital nurse simply because there is no house staff available. We have had evening and night nurses sent to take our course because they were the only registered nurses in their hospitals during their tours of duty. All nurses do not have the same capabilities. One can speculate as to whether there isn't a higher risk involved in admitting a patient to a coronary care unit which is poorly staffed in quantity as well as quality. Hospitals with no house staff have to consider ways of providing medical care to critically ill patients at all times. For example, in one hospital in rural Pennsylvania physicians who admit patients to the coronary care unit take their turn staying in the hospital at night.

A further problem is the lack of critical review of each resuscitation attempt by the team involved. This should preferably take place within 24 hours after the event. Inefficiencies can be repeated if not identified through early analysis.

Another area of concern is the nature of continuing education programs for unit staff. It would be unthinkable to suggest that the subject of arrhythmia detection and treatment could be left to intuition, yet the specific psychosocial knowledge and skills necessary to assist patients, families, and staff in a high stress area where a sizeable proportion of patients will die, has by its apparent absence in crash programs been left entirely to intuition. All staff could benefit, and ultimately patients and families, from planned conferences with a specialist capable of integrating mental health concepts.

For overall nursing morale, there is need to avoid making coronary care nurses an elite hospital clique. Nurses have always been involved in saving lives, though not as dramatically as under the present circumstances. The unit should not be a place where only registered nurses may tread. The shortage of nurses could be reduced if auxiliary personnel such as ward aides, clerks, or technicians were utilized and nurses were used only for nursing care.

The coronary care unit can be a challenging and rewarding area for nursing, because it offers the potential for restoration of the nurse to where she ought to be, with the patient. I say "potential" because it is all too possible for nursing in a unit to become desk-oriented, machine-oriented, or physician-oriented, rather than patient-centered.

Data show that physician-nurse action in coronary care units can indeed accomplish the major objective of saving lives. Survival statistics, however, do not reflect *how* each man lives, or dies there. Evaluation of the quality of care during this crucial phase of human existence should also be our mutual task.

Results In Community Hospitals—Jerome Goldfischer, M.D.

In June 1967 it was estimated that there were some 300 actively functioning coronary care units in the United States. At that time, this comprised less than one half of one per cent of all the hospitals in the nation. As of July of that year all but one of the major hospitals in Bergen County had actively functioning coronary care units and by September of that year the sixth hospital opened its own unit. These six hospitals comprise 2,500 beds, serving a population of about one million people. The total number of beds in these six institutions is 33 coronary care beds. The

smallest unit comprises 4 beds, the largest 7. It is estimated that in 1968 between 1,700 and 2,400 patients will be admitted to these 33 beds as suspected coronaries. Three hospitals have their coronary care units and intensive care units combined. Three have entirely separate coronary care units. In only two of the six hospitals in Bergen County is the house staff totally responsible for patient care. In five of the six hospitals the responsibility for emergency care is vested in the nurse, if there is no attending or house staff member available. By emergency care I mean the use (after proper diagnosis) of intravenous Lidocaine® for potentially serious life threatening arrhythmias and the obligation immediately to defibrillate the patient if the need arises. All hospitals have instituted training courses for nursing personnel with repeat courses given at least once each year. Most of the hospitals had initially sent their nursing personnel to other larger institutions for formal training.

The unit at Englewood Hospital has been in operation since November 1966. Englewood Hospital has a total of 396 beds of which 7 comprise the coronary care unit. The coronary care and the intensive care unit at Englewood Hospital are administratively and geographically separate. The hospital has a house staff comprised mainly of foreign physicians, interns, and residents. They care for all service cases admitted to the coronary care unit and see private patients only when requested to do so by the attending physician. This will vary with the attending doctor and is usually in direct relationship to the severity of the illness. Of course they are always available for emergency therapy, whether on a service or private patient. They sleep in an on-call room adjacent to the unit. In practice, however (on a purely statistical basis), most of the emergency situations are handled initially by the nurses who are well trained to do this. During the fourteen month period ending in December 1967, 503 patients were admitted to the coronary care unit at Englewood Hospital. Of this 503, there were 271 documented acute myocardial infarctions (54 per cent of the total admissions). Of these 271 patients, 196 had documented infarct by history, physical findings, laboratory tests, and classic electrocardiographic findings. Exactly 75 patients, or 28 per cent, had myocardial infarction by all of these modalities, including lactic dehydrogenase isoenzymes, which were diagnostic of myocardial necrosis, but without classic cardiographic changes of infarction. In this group were included patients with left bundle branch block and intraventricular conduction disturbances. Males outnumbered females by roughly 2 to 1. Most of the patients were in the fifth through seventh decades. Thirty-two patients were in clinical shock at the time of admission, 85 were in frank left ventricular failure, of which 31 patients were in frank pulmonary edema. The frequency of arrhythmias that we noted was startling: 180 patients of the 271 had ventricular premature contractions, 152 of them within the first 24 hours. We noted 51 instances of ventricular tachycardia, all within the first 24 hours, and an additional seven during the second 24 hours. There were 13 instances of ventricular fibrillation within the first day of admission, three within the second 24 hours. We have had 25 cardiac arrests in the coronary care unit. Ten were secondary to electrical aberrations and 15 were associated with pure power failure. Of the ten primary electrical arrests, nine were successfully resuscitated. Of the fifteen power failures, we only had three successful resuscitations. Fourteen patients were transferred into the unit, after having had a cardiac arrest elsewhere in the hospital, on the basis of an acute myocardial infarction. Of these fourteen, eleven were primary electrical arrests with ten successful resuscitations. Of the remaining three, all power failure, there were no successes. The mortality rates of any acute unit depend upon many factors, not the least of which is the rapidity of admission to the unit after the time of the onset of pain and the time of discharge. Certainly if there are delays of admission of an acutely ill patient, those who will have electrical aberrations which are potentially life threatening will be

weeded out. Conversely, if critically ill patients are discharged from the unit too early the unit's mortality rate will be markedly improved. Of the 271 patients with acute infarctions, 68 per cent were admitted within the first 12 hours of the onset of pain, and an additional 9 per cent within the first 24 hours. Of this group of 271 patients, 5 per cent had absolutely no pain at all. All patients are retained in the unit for a minimum of three days, and those with arrhythmias for five days after the cessation of all life threatening arrhythmias. Those with pump failure stay until they are stable even though stability may take anywhere from ten to fourteen days to achieve. During this interval, we have had the following mortality rates: 18 deaths in the coronary care unit, 3 primarily electrical and 15 pump, with a mortality rate of 6.6 per cent; we've had 11 deaths in patients who were transferred into the unit after having had infarcts elsewhere in the hospital or cardiac arrests elsewhere in the hospital — mortality rate in this group 4 per cent—with a total mortality rate in the unit of patients either initially admitted or transferred into the unit of 10.7 per cent. We've had a total of 7 per cent late death rate of patients after discharge from the unit, which includes 3.7 per cent of patients who were initially ours and an additional 3.3 per cent of patients who were transferred in, later discharged from the unit and later went on to die. In the death rate are included 6 patients with cerebral vascular accidents, three who died of coincidental carcinomas which were present at the time of infarction. These statistics compare favorably with any of those published to date. They show that with foresight, planning, and initiative the community hospital can provide care equivalent to any given by most of the large university affiliated medical centers.

Training The Nurse— Milton Wiener, M.D.

Dr. Elliot Corday (past president of the American College of Cardiology) has said that the coronary care unit concept is the greatest advance in cardiology of this decade. Based on the sheer number of survivals, this statement is probably justified; and as we begin to appreciate now the meaning of the widespread fallout or spinoff that we see as a result of the coronary care unit concept, this statement of Dr. Corday takes on an even greater significance. The coronary care unit has stimulated a much more active interest in myocardial infarction and heart disease in general, particularly with physicians. Our unit is three and a half years old and I remember clearly how many of us — how many of our experienced physicians — went back to the books to brush up on arrhythmia interpretation when the unit was first established — in self defense. The house staff members, unprepared by their previous schooling or experience for the coronary care unit, have been repeatedly fascinated by the continuous demonstration of applied therapy that is unfolding before their eyes and this has made the coronary care unit a very desirable service from their point of view; and from our point of view, an additional aid to recruitment. Another beneficiary of the coronary care fallout has been nursing in general. The working partnership between the trained coronary care nurse and the physician has obviously created a better understanding of each other's professional role and we are beginning to see this type of relationship spilling over into other spheres of nursing, both in the hospital and in the community.

Since September 1966 we have conducted two-week courses for New Jersey nurses, sponsored by the State Department of Health, and actively co-sponsored by the Bergen County Heart Association. We should be aware of the fact that the availability of the nurse for training, the extent of the training, the budget, the administrative and medical staff cooperation — all of these factors — vary from hospital to hospital, and these may very well be some of the reasons why a number of small voluntary and preparatory hospitals have been unable to support (so far) a coronary care unit. The need to continue training nurses in adequate numbers and at the same time to limit this prohibitive drain on com-

munity hospital resources has stimulated Bergen County to develop a unique and original type of program. This program calls for an area-wide cooperative pooling of available training resources in the community hospitals for a joint use in a most effective and economical manner. We look to the university schools of nursing to train the nursing leadership, to develop standards, and to help evaluate the effectiveness. However, the short term training and retraining of the vast majority of coronary care nurses still remains a local problem. A program of this size, involving ten hospitals in a county of a population of one million, a total of 2,800 beds, is an ambitious program and requires adequate funding. The program has already brought together medical, nursing, and administrative staffs of various hospitals in a region, brought us together at the same table to try to solve some patient care problems, problems that transcend the boundaries of the individual hospital. This unique channel of professional inter-communication has never existed before in this county on such a plane. The latent spirit of cooperation that it has already brought to the surface, I think, has made it clear that the medical practitioner can and will exercise a very constructive role in developing future patterns of health care in his own community. The coronary care unit fallout may very well turn out to be of even more vital significance than the already impressive achievements of the coronary care unit.

Comments By John Kimball, M.D.

The primary role of both the house staff and the nursing staff should be to treat arrhythmias as quickly as possible in the hope that one can control them and actually prevent cardiac arrest from occurring. If you have a house staff immediately available (and when I say immediately available I mean within 20 to 30 seconds), it is appropriate to train them to function and to react immediately to treat these arrhythmias. But, most community hospitals don't have house staffs, or if there is a house staff, they're somewhere around and you can't get them right away. If this is your case you have to make some other arrangements. As Mrs. Germain mentioned, maybe our salvation would be to have physicians on call to the unit — either in the unit or very close by. But, in this situation it is more appropriate to train your nurses to administer drugs and to defibrillate, and to administer electrical therapy (be it electrical shock or turning on the pacemaker in this situation), because we have found, for example, that although we have a physician sleeping on the floor at all times, it takes him 30 seconds to get into the unit and in that period of time the nurse could have administered atropine, could have administered xylocaine; she could have turned on the pacemaker, she could have defibrillated the patient; so that these two groups of professionals have to complement one another. If you have both groups immediately available, good! If you don't, you have to make use of whichever group is the most readily available — your nurses. *We could run our coronary care unit every bit as well as we do without any house staff at all.*

Training is key to the successful coronary care unit; that includes training of your nursing staff, training of your house staff, and retraining, if necessary, of your attending staff. As Mrs. Germain pointed out very appropriately, this is an area that we have neglected, particularly in those coronary care units where the attending physician really does as he pleases regarding the treatment of these patients. Often he does so because he really is not aware of the recent advances that have been made with treatment of arrhythmias. Any time you attempt to have your house staff or your nursing staff assume these key roles, they have to be trained and, of course, in this situation you have to have adequate training at a local level. We've been running a coronary care nurse training course now for two years and our aim has been to train the key nurse in the coronary care unit, because she is the nurse who will go back as the supervisor in charge of running the coronary care unit or the head nurse in charge of running the coronary care unit.

Our aim has been to train her not only to recognize and assist in the treatment of complications of an acute myocardial infarction, but to go back and set up her own nurse training program, an in-service education program to train and retrain the people who will be working in the coronary care units. Although the central agency (central training) units are important, they really cannot possibly train over the long haul the number of nurses necessary to work in coronary care units, so that local training and local in-service education programs will really make or break the successful operation of your own community hospital coronary care unit.

References

1. Day, Hugh, M.D.: *American Journal of Cardiology*, 21:252 (February, 1968)

2. Stein, Leonard: *Archives of General Psychiatry*, 16:699 (June 1967)
3. U.S.P.H.S. Publication #1764. (March 1968)

336 Westwood Avenue, Westwood (Dr. Goldberg)

Coffee May Not Always Be The Cup That Cheers

Once there was a 39-year old waitress who complained for six months about her "cold." Almost every day she had had a low-grade fever. She suffered from chills, lack of sleep, and irritability. After losing 20 pounds, she weighed 107 when admitted to the hospital.

Her trouble? Too much coffee-drinking. She drank eighteen cups a day, the woman told her physician. Her cold symptoms disappeared after five days in a hospital, during which she was limited to one cup of coffee a day.

A report on this case of caffeinism appears in the December 18, 1967 issue of *The Journal* of the American Medical Association. The author is Hobart A. Reimann, M.D., of Hahnemann Medical College, Philadelphia. He pointed out that coffee, tea, dentifrices, and even peanuts contain chemicals called xanthine alkaloids and can induce illness sometimes mistaken for other disease. A cup of coffee contains about one-tenth Gram of caffeine. A single one-Gram dose of caffeine causes mental confusion, shivering, tremor, vomiting, and diarrhea. Ten grams of caffeine can be fatal. The waitress' caffeine intake was probably more than one and a half Grams a day. The intake was spread over several hours, however — probably the reason she was not more seriously ill. This patient also smoked more than a pack of cigarettes a day, and regularly took sleeping pills. The nicotine and drugs also may have affected her reactions to caffeine, Dr. Reimann said.

Effort can be wasted on testing for diseases which a patient does *not* have, but whose symptoms are similar to those caused by excessive use of caffeine and other stimulants. In the waitress' case, Dr. Reimann happened to note that her fever rose after that daily cup of hospital coffee, but declined later. It was then that further questioning disclosed how much coffee she drank. "The cause (of illness) is easily overlooked unless a patient's habits are discovered," Dr. Reimann said. "Prompt recognition eliminates the need for much clinical effort, laboratory testing, unnecessary therapy, and expense."

Reactions to caffeine are influenced by a person's age, emotional state, or by idiosyncrasies. Its effect is widely variable, often opposite in different people or even in the same person at different times. "Caffeinism is said to be current among intellectual workers, actresses, waitresses, nocturnal employees, and long-distance automobile drivers," Dr. Reimann said. "Illness otherwise unexplained may be caused by excessive intake of the xanthine alkaloids, including those in coffee, tea, cocoa, and those in other popular beverages."

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 15, 1968

A regular meeting of the Board of Trustees was held on September 15, 1968 at the Executive Offices in Trenton. For your further information, detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

FLEX (Federation Licensing Examination) . . . Approved in principle the program of the Federation of State Medical Boards of the United States to bring state licensure examinations into better relationship to modern medical education, provided the New Jersey State Board of Medical Examiners is of the opinion that the examinations are comprehensive and fair. (see page 515, September 1968 *Journal*)

AMA Conference on Continuing Medical Education . . . Authorized the Chairman of the Committee on Medical Education (Louis F. Albright, M.D.) to attend the AMA National Conference on Continuing Medical Education in November 1968, in Chicago.

Conference on Tissue Transplantation . . . Authorized the attendance of Joseph J. Timmes, M.D. of Hudson County at the Conference in Washington on Medical-Legal Issues Related to Tissue Transplantation, September 30, 1968.

Advisory Council on Emotionally Disturbed Children . . . Directed that the names of Joseph Kline, M.D. of Trenton and Eugene Resnick, M.D. of Paramus be submitted to the Department of Education for possible appointment to the advisory council to the Department on Emotionally Disturbed Children, to replace the name of Albert Schmidt, M.D. who has moved from New Jersey.

1975 AMA Annual Meeting . . . Referred to the Chairman of New Jersey's AMA delegation, Dr. Joseph P. Donnelly, a communication, endorsed by the Board, from the Atlantic City Convention Bureau, requesting this Society extend to the AMA an invitation to hold its 1975 Annual Meeting in Atlantic City.

Symposium on "Psychiatry for the Physician" . . . Concurred in the following action of the Executive Committee:

> That approval be given to cosponsor, with The Carrier Clinic, the eighth symposium on "Psychiatry for the Physician," to be held in November.

Executive Vice-President of AMA . . . Directed that a letter of appreciation for past courtesies and services in his capacity as Executive Vice-President of the AMA be forwarded to Dr. F. J. L. Blasingame, who has terminated his services with the AMA. (Ernest B. Howard, M.D. has been named Acting Executive Vice-President.)

RhoGAM as a Medical Service . . . Directed that the following opinion of Legal Counsel be forwarded to the New Jersey Obstetrical and Gynecological Society in response to that Society's inquiry:

> That RhoGAM, a blood derivative for women with Rh negative factor, would be interpreted by the courts of New Jersey as being an integral part of a medical service;
>
> That when a required medical service must be provided within limited hours to be effective, the courts of New Jersey would hold the physician responsible for ordering such service regardless of the patient's ability to pay. Such a conclusion on the part of the Courts would be supportive of the principle long embraced by organized medicine that "no one shall be denied necessary medical care because of inability to pay."

. . . Directed that the Department of Health be petitioned to include the cost for this service among those regularly underwritten for medically indigent patients.

Professional Liability and Births . . . Received and filed the following opinions of Legal Counsel:

1. Records which support a physician's service at the birth of a child should be retained for a period of two years beyond that infant's majority (23 years).

2. Three elements are necessary to support a "professional liability suit" —

a. Relations of physician and patient.

b. Physician's failure to provide services meeting established standards.

c. Such failure regarded as proximate cause of injury sustained.

1969 Annual Meeting . . . Approved the report of the Annual Meeting Committee, including the following recommendations:

1. That the third session of the House of Delegates start promptly at 9 a.m., recess at 11:30 a.m. for luncheon, and reconvene at 12:15 p.m., and that this session be limited to the work of the House.

2. That official guests be allowed a 3 minute presentation at the opening session of the House only.

3. That each component society be asked to submit the name of *one* delegate as its official representative to receive a copy of each reference committee report.

4. That the Board make a decision concerning arrangements for its reorganization meeting prior to May 1969.

(The Board agreed to a breakfast meeting on Wednesday, May 21, 1969, starting promptly at 8:30 a.m.)

. . . Approved the proposed daily schedule (see page 619 this issue) with the following suggestion: That the Annual Meeting Committee reevaluate the desirability of scheduling special scientific sessions at the same time as reference committee meetings.

Project Hope . . . Directed that a fellowship of $500 be given to Robert W. Tilney, Jr., M.D., at the beginning of his tour of duty (October 13 to November 15) with the S. S. Hope.

Woman's Auxiliary Program for 1968-1969 . . . Approved the 1968-1969 program of activities for the Woman's Auxiliary, which is identical with that pursued in 1967-1968.

Commission to Study Statutes Relating to Abortion . . . Directed that the following information be brought to the attention of the Speaker of the New Jersey Assembly and the President of the New Jersey Senate, and that it be vigorously urged that the present appointment be revoked and proper appointment be made from the list submitted by this Society on May 19, 1968:

The *Trenton Evening Times* of September 13, 1968 announced the appointment of Dr. W. Fruma Ginsburgh of Princeton as the representative of The Medical Society of New Jersey on a nine-member legislative commission to study statutes relating to abortion and the problem of illegal abortions in the New Jersey.

On May 19, 1968, the Board of Trustees supplied to Mr. Arthur Applebaum, at his request, five nominees for the MSNJ representative on the Commission.

Concurrent Resolution #24 (Sec. 1, lines 9-10) states that one member of the commission is to be a "representative of The Medical Society of New Jersey."

Dr. Ginsburgh does not qualify because she was not one of the nominees officially designated and because she is not a member of The Medical Society of New Jersey.

Joint Meeting with County Presidents . . . Authorized the scheduling of the joint conference of presidents of component societies and the regular meeting of the Board in October at Notre Dame High School in Trenton, and authorized Dr. Louis K. Collins to represent the Board at the morning session of the county presidents.

Retirement Plan for Physicians . . . Requested the chairman of the Committee on Retirement Plan for Physicians (Nicholas E. Marchione, M.D.) to investigate, with the Prudential Insurance Company, the possibility of evolving, under the sponsorship of MSNJ, a plan that would be open to combined groups of component societies, who, because of limited membership, are individually ineligible for the currently popular plan offered by Prudential.

MSNJ Membership of Non-Citizens . . . Directed that the Committee on Credentials be requested to prepare a statement to be issued concerning non-citizen candidates for membership, whose credentials are satisfactory except for the full citizenship requirement in

our current Bylaws. The statement should indicate that the elimination of this requirement will be the subject of House action in 1969.

Essex County Blood Bank . . . Designated Dr. David Eckstein as its official representative in the following matter:

The position of the Essex County Blood Bank is being challenged by the Greater New York Blood Program, whose medical director has stated that the entire area of New Jersey from Trenton to New York falls within his sphere of operation. Essex County requests recognition of the problem and referral to appropriate parties for interpretation and action.

Diabetes Detection Drive November 18-22, 1968

The Diabetes Detection Drive is an attempt to alert the public to the potential hazards of diabetes and its complications. It is a reminder to the physician that diabetes is a multifaceted syndrome. It is an insidious process without the dramatic features of coronary heart disease which brings the patient to the physician's office within a few hours or days.

Diabetes progresses so silently that when it is finally discovered, many complications (which could have been avoided earlier) are now in full bloom and the treating physician may be powerless to help his patient. Today, there are four million diabetics in the United States, half of whom do not know that they harbor the disease.

Diabetes is the number 8 cause of death and the number 3 cause of blindness. One fifth of your patients carry the genes for diabetes. With the increasing longevity of the population, these figures will soon be much higher.

It is imperative that you search for early manifestations of diabetes in its many forms. Check the blood relatives of diabetics, mothers of babies weighing nine pounds or over, children of diabetic parents, obese individuals over forty years of age, and pregnant women with glycosuria.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 24, 1968.

2. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

3. Frequency of Issue: Monthly.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters or general business offices of the publishers (Not printers): 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor, and managing editor. Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, New Jersey; Assistant Editor, Mrs. Marjorie Treptow, 315 West State Street, Trenton, New Jersey.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	8,088	8,144
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail Subscriptions	7,717	7,809
C. Total Paid Circulation	7,717	7,809
D. Free Distribution (including samples) by mail, carrier or other means	333	305
E. Total Distribution (Sum of C and D)	8,050	8,114
F. Office use, left-over, unaccounted, spoiled after printing	38	30
G. Total (sum of E & F should equal net press run shown in A)	8,088	8,144

I certify that the statements made by me above are correct and complete.

Robert H. Lambert
Business Manager
The Medical Society of New Jersey

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of September:

	1968 September	*1967 September*
Aseptic Meningitis	94	18
Primary Encephalitis	6	1
Post-Infectious Encephalitis	2	0
Hepatitis: Total	136	120
Infectious	119	99
Serum	17	21
Malaria	14	18
Military	10	0
Civilian	4	0
Meningococcal Meningitis	5	4
Mumps	27	*
German Measles	2	*
Measles	8	6
Salmonella	60	53
Shigella	8	18

*Reporting only since October, 1967.

Influenza

As most of you are aware there has been a major antigenic shift in the influenza A2 virus which has been isolated in recent epidemics in the Far East. Whether we will have significant illness in New Jersey due to this new strain of Influenza A2 cannot yet be predicted. It is essential that any increased incidence of febrile respiratory illness be promptly reported to the Division of Preventable Diseases (609-292-5590) so that an immediate epidemiologic investigation can be made and virologic studies done. "It is only through extensive surveillance that the true extent of the disease can be determined." This new strain (Influenza A2/Hong Kong 68) has been reported to produce a "mild" influenza type illness.

Drug companies are trying to produce a vaccine effective against this new strain. It is doubtful if it will be produced in significant quantity before the first of the year. At present, it is recommended that the current influenza vaccines be given to persons who are "at high risk" to develop complications as a result of influenza; and that this group be revaccinated once the new vaccine is available. Persons "at high risk" include those of any age who suffer from chronic debilitating diseases, including cardiovascular, pulmonary, renal, or metabolic disorders.

Immune Serum Globulin (ISG) for Prevention of Infectious Hepatitis

(From the Recommendation of the Public Health Service Advisory Committee on Immunization Practices June 1968)

A frequent question asked of our Department is when and to whom gamma globulin (Immune Serum Globulin) should be given for the prevention of infectious hepatitis. Recommendations for several situations are as follows:

1. *Household Contacts:* There is evidence that close personal contact (such as occurs among permanent or even temporary household residents) is important in spreading infectious hepatitis. Secondary attack rates are high for household contacts, particularly children and teenagers. Although secondary attack rates are somewhat lower for adults, their illnesses tend to be more severe. For these reasons, ISG is recommended for all household contacts who have not already had infectious hepatitis.

2. *School Contacts:* Although the highest incidence of hepatitis is among school-age children, contact at school is usually *not* an important means of transmitting this disease. Therefore, routine administration of ISG is *not* indicated for pupil or teacher contacts of a case. However, when epidemiologic study has clearly shown that school or classroom contact is responsible for continued transmission of disease, it is reasonable to administer ISG to individuals at risk.

3. *Institutional Contacts:* In contrast to schools, conditions favoring transmission of infectious hepatitis exist in institutions such as prisons and facilities for the mentally retarded. Sporadic cases as well as epidemics have frequently been reported in such institutions. ISG administered to patient and staff contacts of cases in the doses 0.01 milliliter of ISG per pound of body weight up to 2 milliliters effectively limited the spread of disease in these circumstances.

Where infectious hepatitis exists endemically (particularly in very large institutions with high rates of admission and discharge) residents and staff personnel may be subject to frequent and continuing exposure. Under these conditions, ISG has not resulted in eradication of hepatitis. However, it does provide temporary protection when administered in doses of 0.02 to 0.05 milliliters per pound at the time of admission or employment. It may be necessary to readminister ISG in the same dose after six months if the risk is felt to persist.

The Chemistry Of Heart Failure

The failing heart has no deficiency of high-energy compounds needed to power its contractions, but its ability to tap these energy sources may be impaired in congestive failure, the National Heart Institute now says.

The immediate energy source of heart muscle is adenosine triphosphate (ATP). Large amounts of chemical energy, stored in the chemical bonds linking the phosphate groups of the ATP molecule, are released when these bonds are broken. This energy is made available as needed by enzymes called ATPases, which remove one of the phosphate groups from ATP, then harness the liberated energy to perform useful work. The ATPase of heart muscle is found in myosin, which, with actin, constitute the contractile proteins of the myofibrils.

Drs. Brian M. Chandler, James F. Spann, Jr., Edmund E. Sonnenblick, and Peter E. Pool, of the NHI Cardiology Branch, have demonstrated that the ATPase activity is depressed in myofibrils from failing hearts. Their findings suggest that reduced ATPase activity may be a significant factor in the depressed contractility that limits the pumping effectiveness of the failing heart and renders it incapable of keeping pace with the circulatory needs of the body. Perhaps this will provide clues to the basic defect, that underlies the development of congestive heart failure.

The English scientist A. V. Hill first proposed that the speed at which the heart muscle contracts (contractility) is related to the rate at which ATPase directs the energy release from ATP. Barany of Hungary correlated the ATPase activity with the velocity of contraction by examining a variety of different types of skeletal muscles — from the fast muscles of the frog to the slow muscles of the sloth. Barany found that the muscle's intrinsic speed of contraction is in proportion to the rate of ATPase activity.

Right ventricular failure was experimentally induced in cats by constricting the pulmonary artery. This greatly increased the resistance against which the right ventricle had to work in pumping blood to the lungs. Under this heavy strain, the right ventricle became greatly enlarged, then lapsed into failure. Samples of muscle tissue were taken from the left and right ventricles of both groups of animals. The velocity of contraction of the muscle fibers was measured in a myograph. As expected, the velocity of contraction of fibers from failing right ventricles was substantially slower than that of the fibers from normal right ventricles.

The ATPase activity of muscle fibers from failing right ventricles was 40 per cent lower than that of fibers from normal right ventricles. This depression of ATPase activity was directly proportional to the decreased contractility observed earlier with the myograph. ATPase activity was slightly depressed in muscle samples obtained from the left ventricles in hearts with right ventricular failure, and was normal in normal hearts.

The study results provide further support for Hill's hypothesis that heart muscle contractility is directly related to its ATPase activity, and confirm and extend the earlier work of Barany. Although the cause of the depression in ATPase was not determined, the investigators hypothesied that there may be some relation between depressed ATPase and congestive heart failure.

"Instant" Campus For NJCMD

The New Jersey College of Medicine and Dentistry reports that completion of interim construction will make possible the consolidation of the school's major facilities in time for the opening of classes in September 1969. (Permanent structures are scheduled for completion in 1971.) The administrative headquarters, basic sciences, teaching and research functions, and the college library will be relocated from rented quarters in the Jersey City Medical Center to pre-engineered buildings on the cleared site opposite the former Newark City Hospital, now operated by the College as its Martland Hospital Unit. That hospital and East Orange Veterans Administration Hospital are now the College's principal clinical training centers for physicians. The only major College function remaining in Jersey City will be clinical training in dentistry. This phase of dental training will remain in its Jersey City facilities until 1971.

For Newark the move will mean an increasing number of physicians in the city bringing improved health care to its residents. It will provide the college with space needed for research and instruction. The new buildings will have 186,200 square feet of floor space.

Dr. Robert R. Cadmus, president of New Jersey College of Medicine and Dentistry, hailed the relocation as, "a move that insures the continuing development of New Jersey's first four-year college of Medicine and Dentistry. Not only will the new buildings on our interim campus give us the room that is essential to the programs of the College, but they will reunite the basic science and clinical facilities in Newark, thus facilitating the professional interchange essential to a cohesive program of education and research.

"Furthermore, most College functions will be situated adjacent to the site of our new campus, which will give the people of New Jersey and, particularly, the citizens of Newark the advantages of the most advanced health facilities. By working and studying on their interim campus, the faculty and student body will be part of the vast health program that is developing in Newark. The beneficial effect of this move on faculty and student morale is indeed great."

The permanent structures will comprise a $71 million project, more than half of which has been requested from the federal government. The State of New Jersey has allocated $30 million as its share of the cost. Inter-related structures will include a dental and medical school, specialized training hospital, the administrative headquarters of the College, a medical library, an auditorium, and other teaching facilities, extensive research laboratories, and related service facilities. Also to be included in the College complex is the state's Community Mental Health Center for which funds were approved by referendum.

With its own teaching hospital of 272 beds, the adjacent 760-bed Martland Hospital Unit, and its training capabilities in the 950-bed Veterans Administration Hospital (East Orange), the New Jersey College of Medicine and Dentistry will offer medical students a broad opportunity for clinical educational experience. Dental students also will profit from the availability of these extensive hospital training laboratories.

The attractive, colorful one-story metal structures of the interim campus were utilized to provide quick erection of building units from pre-engineered components under architectural direction. The interim buildings will be blue-toned. There will be enclosed walkways between the buildings. Entrance to the interior campus will be from Bergen Street through a 300-car parking lot. The entire campus will be landscaped. The "instant" campus is designed by Frank Grad & Sons of Newark.

The College now has 500 students, 150 full-time faculty members, and 480 part-time clinical instructors. It was founded in 1956 as the Seton Hall College of Medicine and Dentistry. The State of New Jersey assumed responsibility for the College in 1965.

203rd Annual Meeting

The Medical Society of New Jersey

May 17-20, 1969

Haddon Hall, Atlantic City

Program Outline

Friday, May 16, 1969

4:00 p.m. — Board of Trustees
7:00 p.m. — Buffet Dinner

Saturday, May 17, 1969

10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
3:00 p.m. — House of Delegates and President's Farewell Address
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 18, 1969

9:00 a.m. — Registration Opens
9:30 a.m. — Special Scientific Sessions
10:00 a.m. — Exhibits open
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:45 a.m. — Reference Committees
2:00 p.m. — Motion Picture Theatre
2:30 p.m. — House of Delegates (election)
4:00 p.m. — Inauguration of Incoming President followed by General Session
6:00 p.m. — Inaugural Reception
8:00 p.m. — Exhibitors' Reception-Buffet

Monday, May 19, 1969

9:00 a.m. — Registration and Exhibits open
10:00 a.m. — Motion Picture Theatre
All Day — Scientific Sessions (MSNJ)
2:00 p.m. — Motion Picture Theatre
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 20, 1969

9:00 a.m. — Registration and Exhibits open
9:00 a.m. — House of Delegates
10:00 a.m. — Motion Picture Theatre
All Day — Scientific Sessions (MSNJ)
2:00 p.m. — Motion Picture Theatre
5:00 p.m. — Exhibits and Registration Close

Wednesday, May 21, 1969

8:30 a.m. — Board of Trustees

The Scientific Exhibits — — 203rd Annual Meeting

The following information is pertinent to the scientific exhibit displays at the 203rd Annual Meeting of this Society, May 18 to 20, 1969. Those interested in participating may use the application form on page 621. (Please complete both sides.) Remove the page from *The Journal* and mail directly to Milton Ackerman, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy — It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey — in instances where a pharmaceutical company has aided in the production of an exhibit either through financing or supplying products — that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints or articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

If at all possible, a photograph of the exhibit should accompany the application. If a

photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 15, 1969, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to Milton Ackerman, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, N.J. 08605.

Regulations—Scientific Exhibits

1. *Time:* The Scientific Exhibits officially will open at 10:00 a.m., Sunday, May 18, and will close at 5:00 p.m., Tuesday, May 20. Exhibits will be open on the intervening day from 9:00 a.m. to 5:00 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 11:00 a.m., Saturday, May 17, and all exhibits must be in place by 9:00 a.m., Sunday, May 18. Exhibits must remain intact until 5:00 p.m., Tuesday, May 20, and should be removed from the exhibit hall not later than 12:00 noon, Wednesday, May 21.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign, and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, including electrical connections.

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent*. The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold harmless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

203rd Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 18-20, 1969

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

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3. Is the exhibit free-standing or self-contained? .....
4. Will backwall and dividers be required? (see sketch on reverse side): .....
5. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) .. Minimum inside clear blackwall .....
6. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
7. Has this exhibit been shown in whole or in part at any other scientific meeting? .....

   If so, when? .. and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: .....

Return application to Milton Ackerman, M.D., Chairman Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

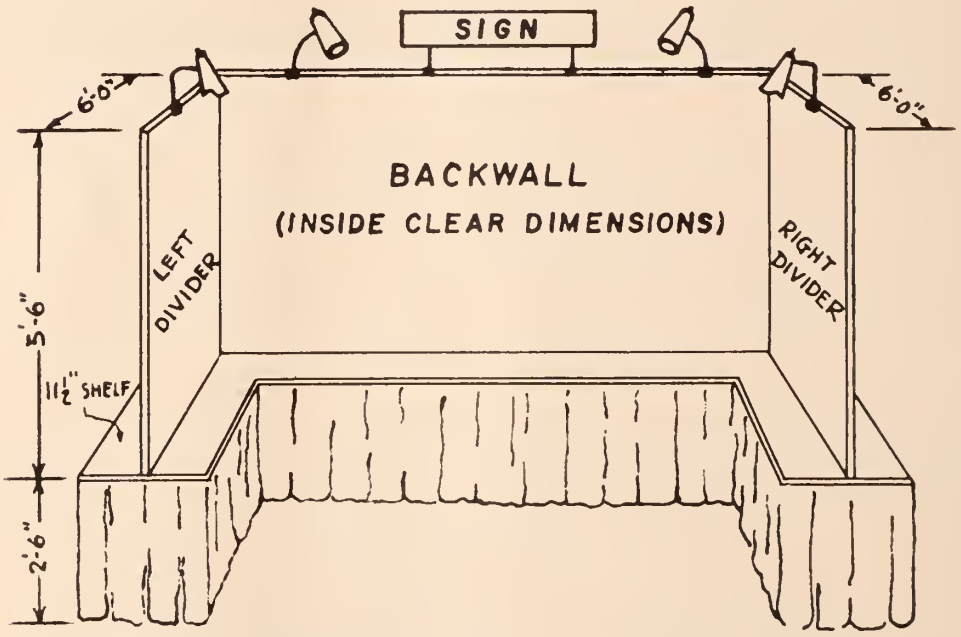
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

ANNOUNCEMENTS

ACP Regional Meetings

On November 13, under the auspices of the American College of Physicians, New Jersey internists will conduct a scientific conference at Rutgers University in New Brunswick. This is one of 34 regional scientific-educational meetings sponsored by the ACP to aid its members in keeping abreast of developments in the basic sciences and clinical medicine. A similar conference, under the auspices of the Eastern Pennsylvania Region of the ACP, will be held in Hershey, Pennsylvania, November 15 to 17. For further information, write to the ACP Governor for New Jersey, Dr. James F. Gleason, 7 S. Oxford Avenue, Ventnor, or the Eastern Pennsylvania Governor, Dr. George D. Ludwig, 3600 Spruce Street, Philadelphia.

Hahnemann Sponsors Special Courses

The Hahnemann Medical College announces a number of courses to be held in Philadelphia in the 1968-1969 season, as follows:

Each Wednesday afternoon, through April 16, 1969 — Internal Medicine

November 22, 1968 — Three day symposium on Psychedelic Drugs

March 31, 1969 — Three day program on Psychiatry for Internists

July 7 through July 11, 1969 — Clinical Electrocardiography

July 14 through July 18, 1969 — Interpreting the Arrhythmias

August 11 through August 17, 1969 — Five day compact course in Space Medicine

For details and registration, write to the Director of Continuing Education, Hahnemann Medical College, 230 North Broad Street, Philadelphia 19102.

Colon and Rectal Society Meeting

The Pennsylvania Society of Colon and Rectal Surgery will hold its Annual Oration Meeting at the Union League, Broad and Samson Streets Philadelphia, on January 10, 1969. Guests are welcome. Neil W. Swinton, M.D. of the Lahey Clinic in Boston will speak on "Management of Adenomatous Polyps of the Colon and Rectum." Cocktails will be served at 6:30 and dinner at 7:30 (black tie preferred). Reservations may be made with Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia — $12.50 per person. (Please make check payable to the Pennsylvania Society of Colon and Rectal Surgery.)

Eye And Ear Conference In New York

The next clinical conference of the New York Eye and Ear Infirmary will be held at the Biltmore Hotel in New York, February 27 and 28, and March 1, 1969. The registration fee is $20. For further information please write to Jane Stark, Registrar, Alumni Association, New York Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

Pulmonary Physiology: A Philadelphia Program

An intensive five day course in all aspects of pulmonary physiology is scheduled for March 3 through 7, 1969 in Philadelphia, under the auspices of the University of Pennsylvania. The fee is $75. For registration and more information, write to the Graduate School of Medicine, 237 Medical Laboratories Building, University of Pennsylvania, Philadelphia 19104.

Pulmonary Disease Course

The first 50 physicians to apply will be admitted to the course in the diagnosis and care of pulmonary problems developed by the

University of Pennsylvania. The course starts on March 10, 1969 and terminates on March 21. The fee is $150. For details, write to the Division of Graduate Medicine, Medical Laboratories, Philadelphia 19104. (University of Pennsylvania)

Conference on Rural Health

The first day of spring is March 21. And on that day, an exciting Conference on Rural Health opens in Philadelphia at the Marriott Motel. It is AMA-sponsored and an exceptionally fine faculty has been assembled. Topics for discussion include rural emergencies, systemic health planning in rural areas, recruiting medical and dental manpower, the role of the nurse, problems of migrant farm workers, and the development of the interesting crossroads medical center. For more information, write to Chairman, Council on Rural Health, American Medical Association, 535 North Dearborn Street, Chicago 60610.

Chairmen Councils and Committees 1968-1969

Air Pollution
Roslyn Barbash, M.D., Teaneck

Alcoholism
Henry J. Mineur, M.D., Cranford

Annual Meeting
Jerome G. Kaufman, M.D., Maplewood

Cancer Control
John L. Olpp, M.D., Englewood

Child Health
William J. Farley, M.D., Nutley

Conservation of Vision
Frank B. Vanderbeek, M.D., Paterson

Credentials
Marcus H. Greifinger, M.D., Newark

Drug Addiction
Henry A. Davidson, M.D., Cedar Grove

Judicial
Albert F. Moriconi, M.D., Trenton

Emergency Medical Care
Jack R. Karel, M.D., Hillside

Emotional Disorders of Childhood and Adolescence
Eugene V. Resnick, M.D., Paramus

Finance and Budget
Thomas C. DeCecio, M.D., Cliffside Park

Honorary Membership
Ralph M. L. Buchanan, M.D., Phillipsburg

Legislation
Jesse McCall, M.D., Newton

Maternal and Infant Welfare
John D. Preece, M.D., Trenton

Medical Defense and Insurance
Fred A. Mettler, M.D., Blairstown

Medical Education
Louis F. Albright, M.D., Spring Lake

Medical Services
Louis K. Collins, M.D., Glassboro

Medical Student Loan Fund
Frank J. Hughes, M.D., Gloucester

Medicine and Religion
Luke A. Mulligan, M.D., Leonia

Mental Health
Robert S. Garber, M.D., Belle Mead

Mental Retardation
Miles E. Drake, M.D., Vineland

Occupational Health, Workmen's Comp. & Rehab.
Joseph A. Lepree, M.D., Elizabeth

Project Hope — Vietnam
Thomas C. DeCecio, M.D., Cliffside Park

Publication
George B. Sharbaugh, M.D., Trenton

Public Health
John P. Coughlin, M.D., Jersey City

Public Relations
John J. Crosby, M.D., Jersey Ciy

Retirement Plan for Physicians
Nicholas E. Marchione, M.D., Vineland

Revision of Constitution and Bylaws
John J. Thompson, M.D., Caldwell

Seizures
J. Lloyd Morrow, M.D., Passaic

Traffic Safety
Irwin S. Smith, M.D., Willingboro

Woman's Auxiliary Advisory
George O. Rowohlt, M.D., Dumont

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
November

7 **The Academy of Medicine of New Jersey**
Section on Pediatrics
Rutgers Institute of Microbiology
New Brunswick
Memorial Program for Charles H. Smith, M.D.

8 **New Jersey Academy of Science**
Rutgers Universiy
New Brunswick
Symposium: "Influence of Cold on Metabolic Regulation"

12 **Bergen County Medical Society**

12 **Newark Eye and Ear Infirmary and American Academy of General Practice**
45 S. 10th Street
Newark
"Amblyopia"

13 **The Academy of Medicine of New Jersey**
The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Genitourinary Infection in Diabetes"

13 **Gloucester County Tuberculosis and Health Association**

13 **Middlesex County Medical Society**

13 **Ocean County Medical Society**

13 **American College of Physicians**
New Jersey Regional Meeting
Rutgers University Medical School

14 **Essex County Medical Society**

14 **Hospital Center at Orange**
Orthopedic Hospital
Orange
Symposium: "Muscle Disease"

19 **Newark Eye and Ear Infirmary and American Academy of General Practice**
45 S. 10th Street
Newark
"Differential Diagnosis of Masses in the Neck"

20 **New Jersey State Dental Society**
Semiannual Session

20 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Disturbances of Pituitary Function"

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"The Family Physician's Role in Prevention of Coronary Heart Disease"

20 and 27 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

20 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Martland Hospital
Newark
Symposium: "Adolescent Endocrinology"

20 **The Academy of Medicine of New Jersey and New Jersey Academy of Ophthalmology and Otolaryngology**
Hotel Robert Treat
Newark
Symposium

20 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"The Circulating Thyroid Hormones: Recent Advances"

20 and 27 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

21 **Gloucester County Medical Society**

21 **Morris County Medical Society**

25 **Cape May County Medical Society**

26 **Hunterdon County Medical Society**

26 **Newark Eye and Ear Infirmary and American Academy of General Practice**
45 S. 10th Street
Newark
"Head Injuries"

27 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Control of Male Fertility"

December

3 **Hudson County Medical Society**

4 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Calcium and Phosphorus Metabolism"

4 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Metabolism of Adipose Tissue"

4, 11 and 18 **Morristown Memorial Hospital with The Institute of the Pennsylvania Hospital**
Morristown
"Emotional Aspects of Illness"

4, 11 and 18 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

5-6 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Newark City Hospital
Workshop on Culdoscopy

7 **American College of Surgeons, New Jersey Chapter**
Newark Beth Israel Hospital
Newark
Annual Meeting

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

11 **Gloucester County Tuberculosis and Health Association**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Hypercalcemias"

11 **Mercer County Medical Society**
Trenton State Hospital
Seminar: "Emotional needs of Adolescents"

18 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Regulation of Insulin Secretion"

18 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Cardiogenic Shock"

26 **Gloucester County Medical Society**

26 **Morris County Medical Society**

1969
January

7 **Hudson County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 and 15 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

8 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Rationale for Modern Treatment of Diabetes"

14 **Bergen County Medical Society**

15 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"New Aspects of Cor Pulmonale"

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Medicare and Medicaid in Family Practice"

22 **The Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: "Coronary Care"

22 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Diabetes Mellitus"

22 and 29 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

27 **Cape May County Medical Society**

28 **Hunterdon County Medical Society**

29 **The Academy of Medicine of New Jersey**
Section on Pediatrics
Morristown Memorial Hospital
"Neuroblastomas"

February

4 **Hudson County Medical Society**

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

14-15 **American College of Surgeons**
New Jersey Chapter
Trip to Cleveland Clinic
Cleveland, Ohio

18 **Warren County Medical Society**

19 **The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Symposium: "What's New in Cancer"

19 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment of Ski injuries"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Cancer Chemotherapy"

26 to Mar. 1 **New Jersey Academy of General Practice**
Sheraton-Deauville Hotel
Atlantic City
Convention

March
4 **Hudson County Medical Society**

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Marriott Motor Inn
Saddle River
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

19 **The Academy of Medicine of New Jersey**
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Rheumatic Fever: Diagnosis and Treatment"

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

31 **Cape May County Medical Society**

April
1 **Hudson County Medical Society**

2 **The Academy of Medicine of New Jersey**
Symposium on Gynecology

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

2 and 9 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Pediatric Symposium

16 **The Academy of Medicine of New Jersey**
VA Hospital, East Orange
Dental Symposium

16 and 23 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

26 **Kessler Institute of Rehabilitation**
Mayfair Farms
West Orange
20th Anniversary Dinner

May

6 **Hudson County Medical Society**

7 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

13 **Bergen County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Ocean County Medical Society**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

17-21 **MSNJ Annual Meeting**
Haddon Hall
Atlantic City

18 **The Academy of Medicine of New Jersey**
Symposium: "The Diagnosis of Life and Death

20 **Warren County Medical Society**

21 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

22 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

26 **Cape May County Medical Society**

27 **Hunterdon County Medical Society**

28 **Middlesex County Medical Society**

OBITUARIES

Dr. Charles D. Driscoll

One of the Camden County's leading internists, Dr. Charles D. Driscoll of West Collingswood, died on September 20, 1968 at the age of 68. He was a senior attending physician at Cooper Hospital, a Board Diplomate in Internal Medicine, a Fellow of the American College of Physicians, and a Colonel in the Reserve Corps of the U.S. Army. During the war, he was on active duty in the Medical Corps with the rank of full colonel. He was a member of the class of 1931 at the Jefferson Medical College.

Dr. Raffaele Ferrigni

One of East Orange's well known family doctors, Raffaele Ferrigni, died on July 19, 1968 at the age of 59. He was a 1928 graduate of the Medical School of the University ol Naples. He was a general practitioner affiliated with the Columbus Hospital in Newark, and was a senior staff physician at the Essex County Hospital in Belleville. Dr. Ferrigni was active in the affairs of the Essex County Medical Society.

Dr. William J. Gleeson

A recent past-president of the Hudson County Medical Society, Dr. William J. Gleeson, had a fatal heart attack on August 28, 1968. Dr. Gleeson, one of our state's leading anesthesiologists, was professor of that subject at the New Jersey College of Medicine. He was 64 at the time of his death. Dr. Gleeson earned his M.D. degree at Bellevue in 1927. He was chief of anesthesiology at the Jersey City Medical Center, and on the consultants' advisory panel on anesthesiology for Blue Shield.

Dr. George Kerdasha

Dr. George Kerdasha was one of the state's pioneer pediatricians. Born in 1896, he was graduated in 1922 from the Medical School of the University of Maryland. He became chief of the pediatric service at the North Hudson Hospital in Weehawken, and was associate pediatrician at the Christ Hospital in Jersey City. Dr. Kerdasha died on July 11, 1968 at the age of 72.

Dr. Frank V. Merlo

At the untimely age of 58, Dr. Frank Merlo, a member of our Union County Medical Society, died on September 12, 1968. He was a 1936 graduate of the Medical School of Georgetown University. Dr. Merlo was an anesthesiologist at both the Alexian Brothers and St. Elizabeth Hospitals in Elizabeth. He was a Fellow of the American College of Anesthesiologists.

Dr. Joseph A. Schramm

Essex County lost one of its senior practitioners on July 19, 1968 with the death that day of Dr. Joseph A. Schramm, at the age of 79. Dr. Schramm was a Bellevue graduate in the class of 1913. Immediately on completion of his internship in the fall of 1914, he went to Canada and sought a commission in the medical corps of the Canadian Army. With the entry of the USA into World War I, Captain Schramm transferred to his own country's medical corps and served with distinction in France. Mustered out in 1920, he went into general practice in Newark, and served the people of Essex County until his retirement at the age of 75. For many years, he was active in the affairs of the Essex County Medical Society.

Dr. Norman Szold

An alumnus of the Medical School of Long Island University, class of 1933, Dr. Norman F. Szold died on September 4, 1968 at the age of 63. He was a surgeon on the staff of the Paul Kimball Hospital in Lakewood, and was active in committee work for the Ocean County Medical Society. Dr. Szold was a Fellow of the International College of Surgeons. During World War II, he served as a major in the Army of the United States.

BOOK REVIEWS

Electrocardiographic Notebook, Ed. 3. M. Irene Ferrer, M.D. New York, 1968, Hoeber Medical Division, Harper and Row. Pp. 114. Illustrations 54. ($3.45).

The *Electrocardiographic Notebook* is exactly what it purports to be: a succinct compilation of electrocardiography covering the major features of the electrocardiogram and its generation without going into all of the minutiae and details. Its format and size make it ideal for the intern or resident to carry in his pocket and for this reason it is handy.

However, it has certain marked disadvantages. All of the tables and illustrations are at the end of the book so that the reader is forced to oscillate from front to back to see what the author is trying to describe. This is a nuisance. Many pages in the section of figures and tables are not numbered, making for further difficulties. Compounding the problem is that even the tables are not sequential, e.g. table 1a is 10 pages in front of figure 1b. Nevertheless, the author has compiled some very useful information in these tables for the intern or resident who needs a quick reference. There are, for instance rate as well as maximal QT intervals. The Lewis and Golub leads, useful in demonstrating atrial arrhythmias, are illustrated.

Though this book has many undesirable features it has certain qualities which make it most useful for the intern or resident. With the increase in the number of coronary case units and the reliance placed upon nurses for recognition of arrhythmias and other abnormalities this book may be of value to them as a quick reference after they have completed their training. However, it probably has no place in the library of the serious student of electrocardiography.

ARTHUR BERNSTEIN, M.D.

Today's Health Guide. Edited by W. W. Bauer, M.D. Chicago, 1968, American Medical Association. Pp. 624. Illustrated. ($5)

A sophisticated and intelligently written health guide for the American family is here presented in a beautifully illustrated, well-bound, 624 page hard-backed book. At today's prices, this is certainly a remarkable value. Each section is written by an unquestioned authority in the field. The text touches on the anatomy and physiology of the human machine, on infant feeding and sex education, on health problems in foreign travel, on home nursing technics and obesity, on quackery and medical folklore, on surgery and physical handicaps, on community health and rheumatism, and on and on, covering in extraordinarily compact, authentic, and readable fashion what should be known about almost every facet of sickness and health. The book is a kind of health insurance policy for the mature family-head, a one-volume reference encyclopedia and a practical manual of first aid all rolled into one. In the end pages, for swift reference, is a compendium of advice on handling emergencies. This is certainly the best book of its kind.

VICTOR HUBERMAN, M.D.

A Doctor Discusses Narcotic and Drug Addiction. Louis Relin in consultation with R. L. Sharoff, M.D. Chicago, 1968, Budlong Press. Pp. 90. Paperback. ($1.75)

Written for the reasonably sophisticated layman, this book lays it on the line with respect to addicting and habit forming drugs. It covers opiate alkaloids, barbiturates, hallucinogens, marijuana, tranquilizers, glue sniffing, and amphetamines. Included is a glossary of slang terms used for these drugs. A unique feature of the text is a series of doctor-patient dialogues on how the patient got hooked, how the physician can answer the patient's queries without sermonizing, and where to find the road out of "drugville." This useful little book is available "through professional sources only" — that is, it can't be bought wherever paper backs are sold, but is intended for distribution by the physician. I can see three uses for this text. It is an excellent source book for the physician invited to give a talk to a lay audience (or high school or college class); it is a silent but, I think, rather useful item to give to an addict or his parent; and it compresses within a small compass a lot of material on the subject that not all of us know about.

HENRY A. DAVIDSON, M.D.

The Country Doctor and the Specialist. Fred Adair, M.D. Maitland, Florida, 1968, Adair Charities. Pp. 215 (Price not stated)

Fred Adair, now in his nineties, who did the original clinical research on ergonovine, writes of his youth and of his later organizational contributions. His efforts, no question, laid the ground work of prenatal clinics in the United States and raised the level of obstetric and gynecologic standards of both hospitals and medical schools in the United States. The latter portion of the book is an uninspired recountal of his efforts; but like the dog that stood on his hind legs, the point is not that it's good, (it isn't) but that at 92 he could do it at all.

The first few pages tell of his father's efforts as a country doctor to establish a practice. The old Doctor Adair wrote in 1870 to his wife-to-be "Dr. Blakesley had a very bad patient and would not call me in counsel but sent away and after all had to come for some of my chloral. . . . That is what I like to see. I took two more of his patients yesterday and today, and if he don't look out I will have the balance he has on hand if he has any. Guess he doesn't have many anyway." Tant que le monde change, c'est la meme chose.

SIDNEY FRIEDENBERG, M.D.

Put-Offs and Come-Ons A. H. Chapman, M.D., New York, 1968, Putnam. Pp. 256. ($5.95)

To Dr. Chapman, neurotic symptoms are maneuvers or strategems which either draw people together (come-ons) or wedge people apart (put-offs). All neurotic symptoms are thus interpreted, as if they were games. And psychiatric treatment is also visualized as a ploy of maneuver or manipulation — both the psychiatrist and the patient playing the game. This breezy book is a bit heavy on the side of whimsy and somewhat overstrained in its effort to find cute phrases. But the psychiatric mechanisms do ring true, and the text is smoothly written and attention arresting. There is a certain lack of depth and concreteness in its approach to treatment technics. On the other hand, the book does call attention to many easily overlooked psychologic mechanisms in the development of symptoms and in the doctor-patient relationship.

FELIX A. UCKO, M.D.

Monoclonal and Polyclonal Hypergammaglobulinemia: Clinical and Biological Significance. Jan G. Waldenström, Nashville, 1968 Vanderbilt University Press. Pp. 223. Illustrations ($6.95)

Professor Waldenström, known for his monumental and pioneering work in blood proteins, has now produced a book concerned with the correlation of the clinical and the biologic significance of the immunoglobulins. These proteins of the antibody system consist chiefly of the gamma globulins, though other globulins may also take some part in the reactions. Recently, analysis of gamma globulins has been largely based on observations of abnormal conditions such as macroglobulinemia (to which the author's name has been attached) and hypergammaglobulinemia.

The division of the latter condition into monoclonal and polyclonal groups is based on the examination of the associated disease states. In the former group, only one cell line is proliferated; in the latter many cell lines produce normal and abnormal gamma globulins. Waldenström relates these abnormalities of blood proteins to autoimmune diseases and describes cases he has investigated. He considers the underlying genetic, biochemical, physiochemical, and serologic implications of this work and discusses the relevance to metabolic derangements in myeloma and other malignancies.

The book will be particularly interesting to the clinicians concerned with the diagnosis and treatment of malignant and collogen diseases and to protein biochemists, immunologists, and hematologists.

MELVIN H. FREUNDLICH, M.D.

Interferon (Ciba Foundation Symposium). Edited by G. E. W. Wolstersholme and Maeve O'Connor. Boston 1968, Little, Brown and Company. Pp. 284. Illustrations 54. ($12.00)

This excellent book offers complete information about interferon. It was written by experts from many nations in this difficult area of virology. It includes fifteen major presentations each followed by an interesting discussion by several participants in this 1967 Ciba Symposium. The formal talks include the mechanisms of interferon formation, its purification, its action, and the effect of carcinogenic agents on its production and activity.

This is not light bedside reading, but rather is medical science at a high level. The book is certainly recommended for virologists and pathologists who wish to keep abreast of this important medical advance. A thorough reading of this symposium offers a stimulating review of modern virology with all of its ramifications and associations with DNA and RNA.

HUGH F. LUDDECKE, M.D.

Nutrition and Infection (Ciba Foundation Study Group No. 31). Edited by G. E. W. Wolstenholme and Maeve O'Conner. Boston, 1968. Little Brown and Company. Pp. 151 Illustrations 20. ($3.50).

The Ciba Foundation was established in 1949 to promote international cooperation in medical and chemical research among scientists from all parts of the world. It meets in London and annually organizes short symposia. This book details the results of the 1967 meeting.

Eight papers are presented, followed by informal discussions, covering the fields of nutrition, infection, growth, and development in certain African states and in Central America.

Most of the conclusions reached emphasize what has been common knowledge for many years: poor nutrition turns mild infections into major catastrophies; and, as a corollary, chronic exposure to parasites and other infections induces anorexia and poor food intake, leading eventually to malnutrition and starvation.

HARRY M. POPPICK, M.D.

The Doctor and the Athlete. Ifao Hirata, Jr., M.D. Philadelphia, 1968, J. B. Lippincott. Pp. 282. Illustrated ($11.00)

The orthopedist, general practitioner, internist, (or even obstetrician) who has the direct responsibility for injuries and disabilities of athletes, be they Little Leaguers, high-school players, or professionals, should have a reference library available for consultation. Here is an ideal book for this purpose. Its format lends itself to leisure time reading and represents a departure from the usual "text book." It includes a statement of general principles and represents a reasonable approach to many of the problems facing a team physician in his relationship with the athlete, the parent, the coaching staff, and the trainers.

Part II of the book concerns specific injuries and disabilities. An occasional line drawing is presented and there are no radiologic representations. Half of the illustrations are included in the chapter on athletic taping which occupies six pages including illustrations.

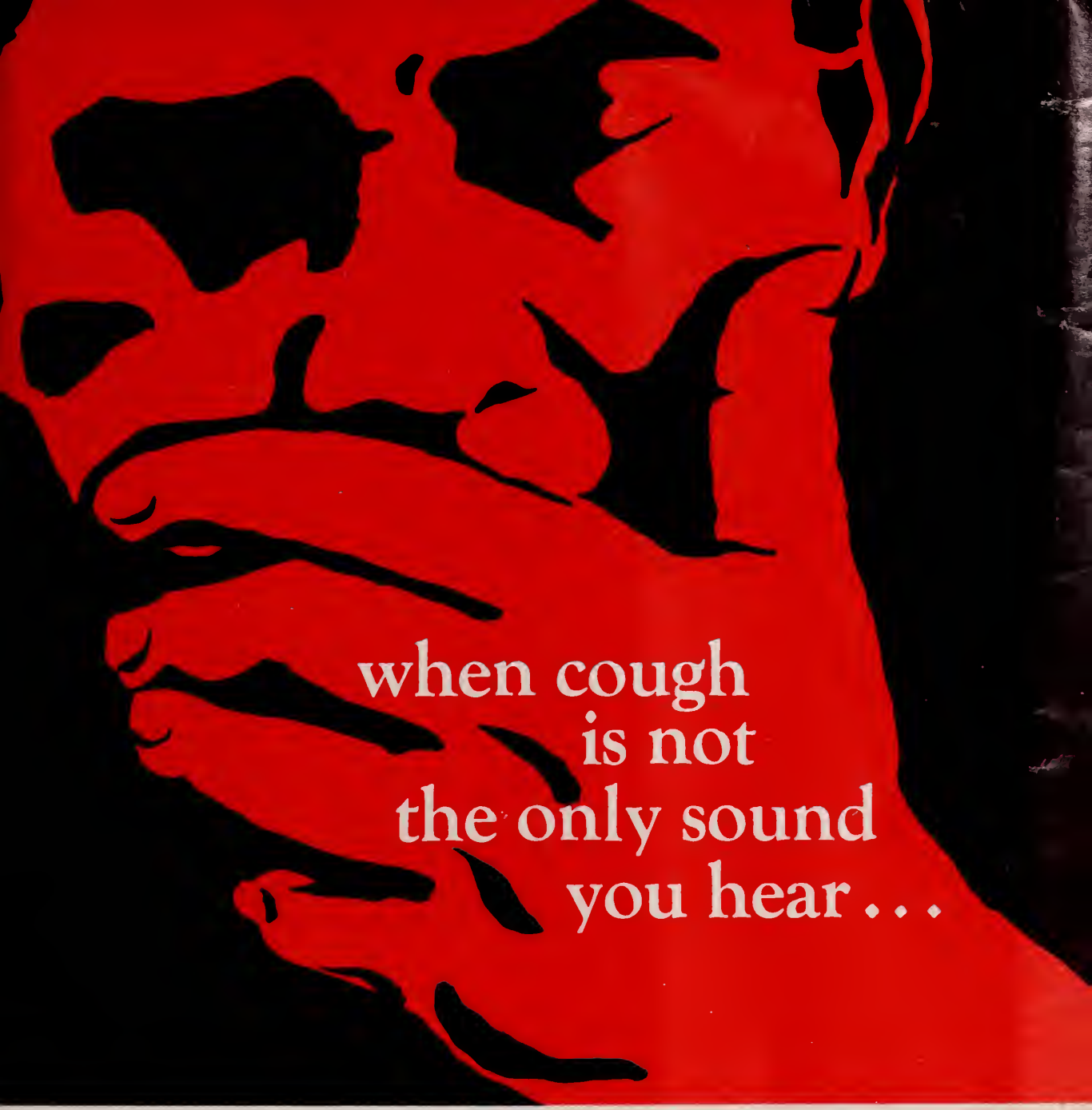
The Doctor and the Athlete is a worthwhile addition to the mounting reservoir of literature on athletes. It is far from being a compendium. However, it would be a valuable addition to any physician's library if the doctor is at all connected with athletics or considering supervising an athletic program.

R. THEODORE NUSSDORF, M.D.

Biologic Treatment of Mental Illness. Edited by Max Rinkel, M.D. New York, 1966, Farrar, Straus and Giiroux. ($25) Pp. 1024.

In 1962 the Manfred Sakel Foundation held a conference on the biologic treatment of mental illness. The papers read and the discussions about them constitute the text of this $25 book. Controversy still rages as to whether anxiety is of emotional or chemical origin; as to whether schizophrenia is simply a poorly learned habit of living, or the end product of a disease of the brain. This book, of course, is in the "organic" camp. It review progress in biochemistry, electroconvulsive treatment, insulin shock, endocrine drugs, and so on. The papers range over the world with special attention to the patterns of mental illness in India, Thailand, Ceylon, South America and so on. Nor are the anthropologic, criminologic, social, and existential problems ignored. The traditional psychodynamic interpretations get short shrift, but the reader is warned of that by the very title of the book. At any rate, most experts do believe that neurotic and psychotic disorders come from disturbance in the mind; that the mind is housed in the brain; and that the brain is an organ to be studied like the liver or the ovary. By now, the "analytic" or "psychodynamic" explanation of emotional disorders has become the conventional, indeed the "established" dogma. Seventy-five years ago this approach came like a fresh breeze to doctors looking for the germs that caused emotional illness. Today the positions are reversed.

ABRAHAM LEFF, M.D.



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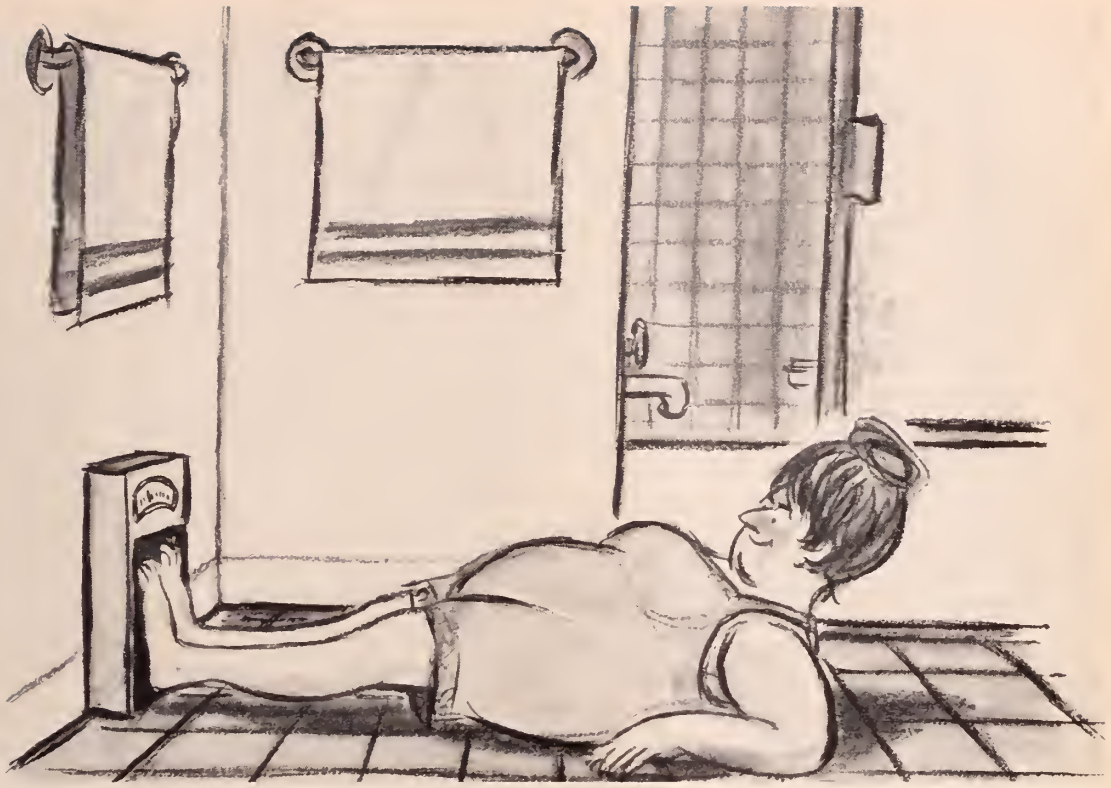
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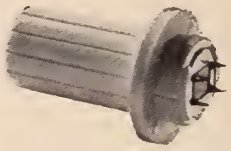
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The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

or headache, a sovereign remedy was
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A realistic approach to pain relief



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Tuckahoe, N.Y.

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The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

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When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

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hat's because of its prolonged ction, which usually provides mooth diuretic activity roughout the day. And ne-a-day dosage means few blets to take and few tablets pay for in the long run.

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in edema and hypertension

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Indications: Hypertension and many types of edema involving retention of salt and water.

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Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

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Noncommercial Aspects Of Medical Advertising

With our present cynicism about Madison Avenue and all its works, many of us see medical advertising as simply a hard sell to lure money from unsuspecting patients. Actually it is more than that. The company which makes the product advertised (whether a drug or an appliance) has involved itself in planning, research, and preparation. It has to know the product, know what the physician wants, and, above all, know what will help the patient. The advertiser needs skilled advisers with respect to the artistry of the display. The company is bound by a burgeoning book of rules and regulations about the honesty of his claims, the effectiveness of his product, and the possible contra-indications and side effects. He has to pass the critical screening imposed by the officials of the sponsoring society. The Federal Trade Commission and the Food and Drug Administration keep a pair of eagle eyes on his advertising copy.

Critics sometimes make fun of doctors who learn about medical progress through advertising or through the information furnished by manufacturers' service representatives (to you, known as "detail men"). Actually, it is impossible for any physician to keep in touch with everything in his field, and the advertisers have developed considerable skill in extracting the essence of research studies. Naturally, they focus on results that support their own claims. But most researchers do that anyway, and the doctor is presumably sophisticated enough to weigh claims with some objectivity and reservation. No reputable manufacturer is going to risk his reputation by publishing false claims — and nonreputable ones don't get into the advertising sections of society-sponsored medical journals. A tour through the advertising pages of this, or any similar journal, is like a tour through the exhibits at a scientific convention. You are expected to read the copy with judgement and discrimination, just as you survey scientific exhibits. The advertising pages do not represent instant education. To that, there are no short cuts. But they are not simply a collection of extravagant puffs, either. They are a show-case of solid, usable, screened, and well-displayed information.

(This editorial appeared in the October 1967 JOURNAL, page 548)

Through these doors pass the world's best excuses for not using safety belts.



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Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Lederle

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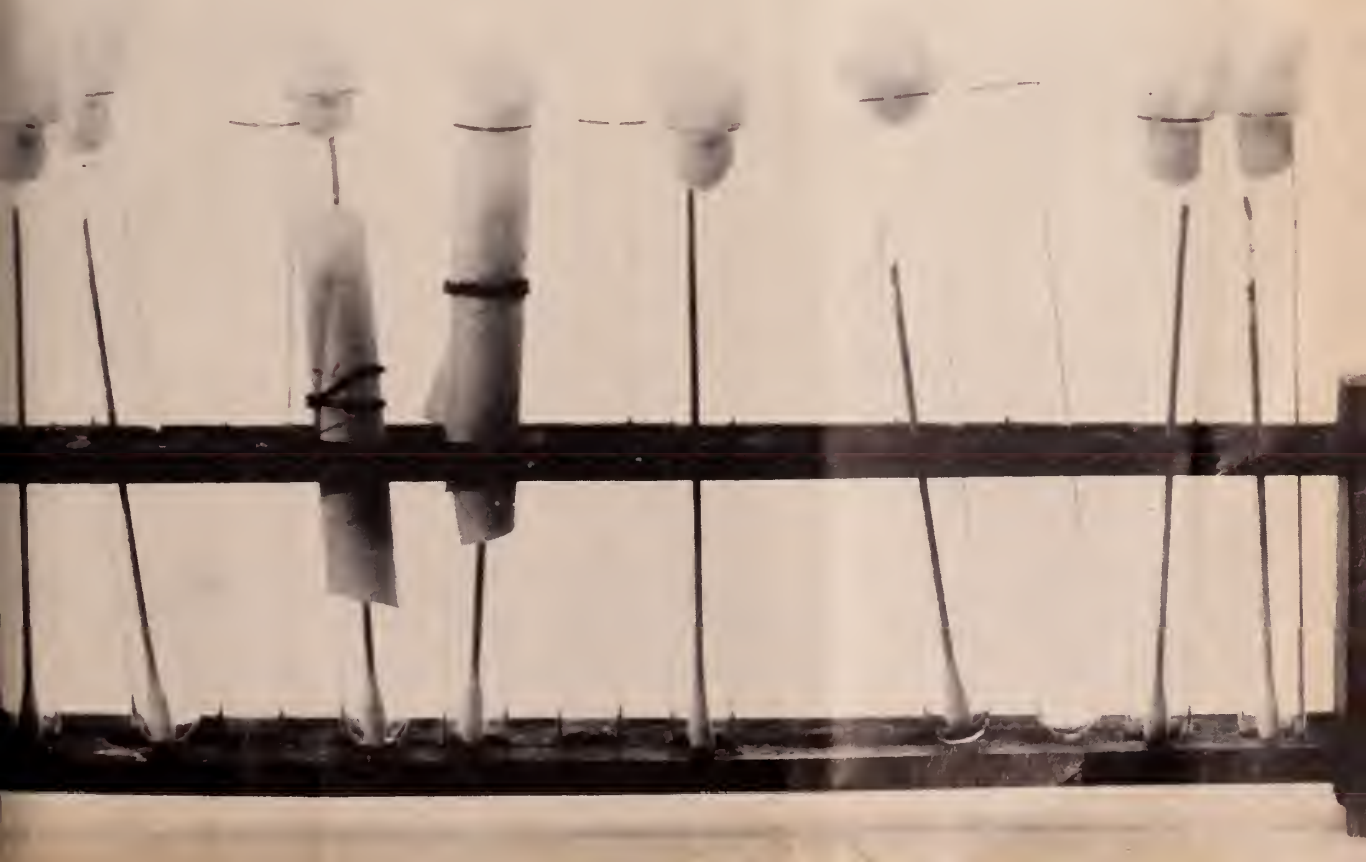
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SEE TOPIC LISTING ON PAGE 568

October 1968

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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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the JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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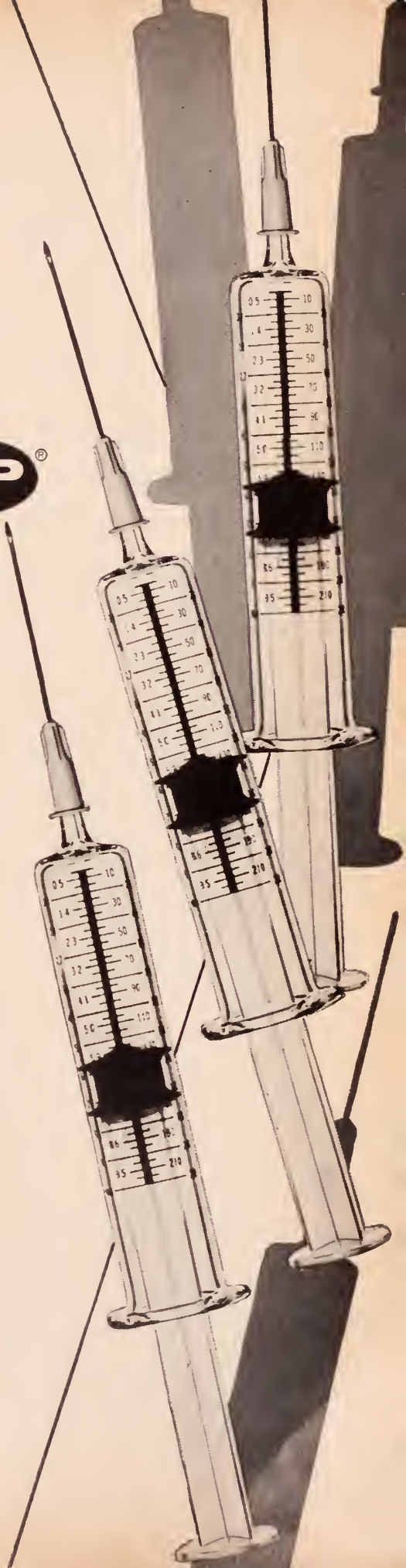
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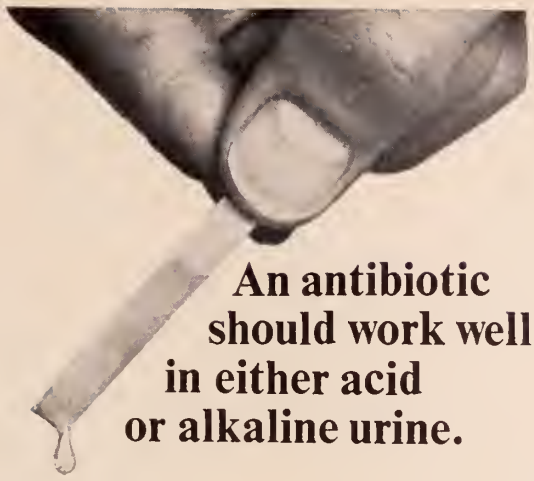
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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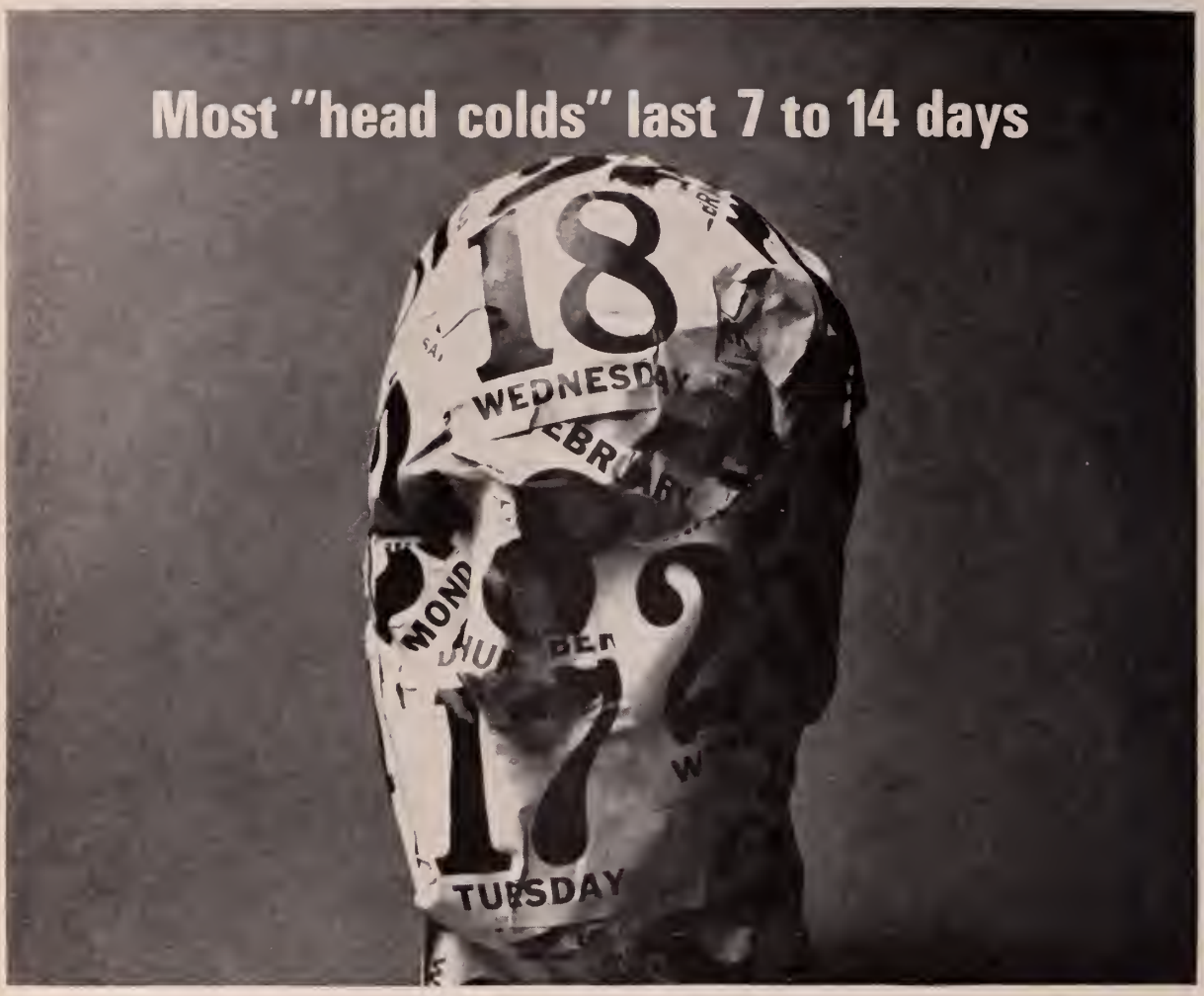
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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



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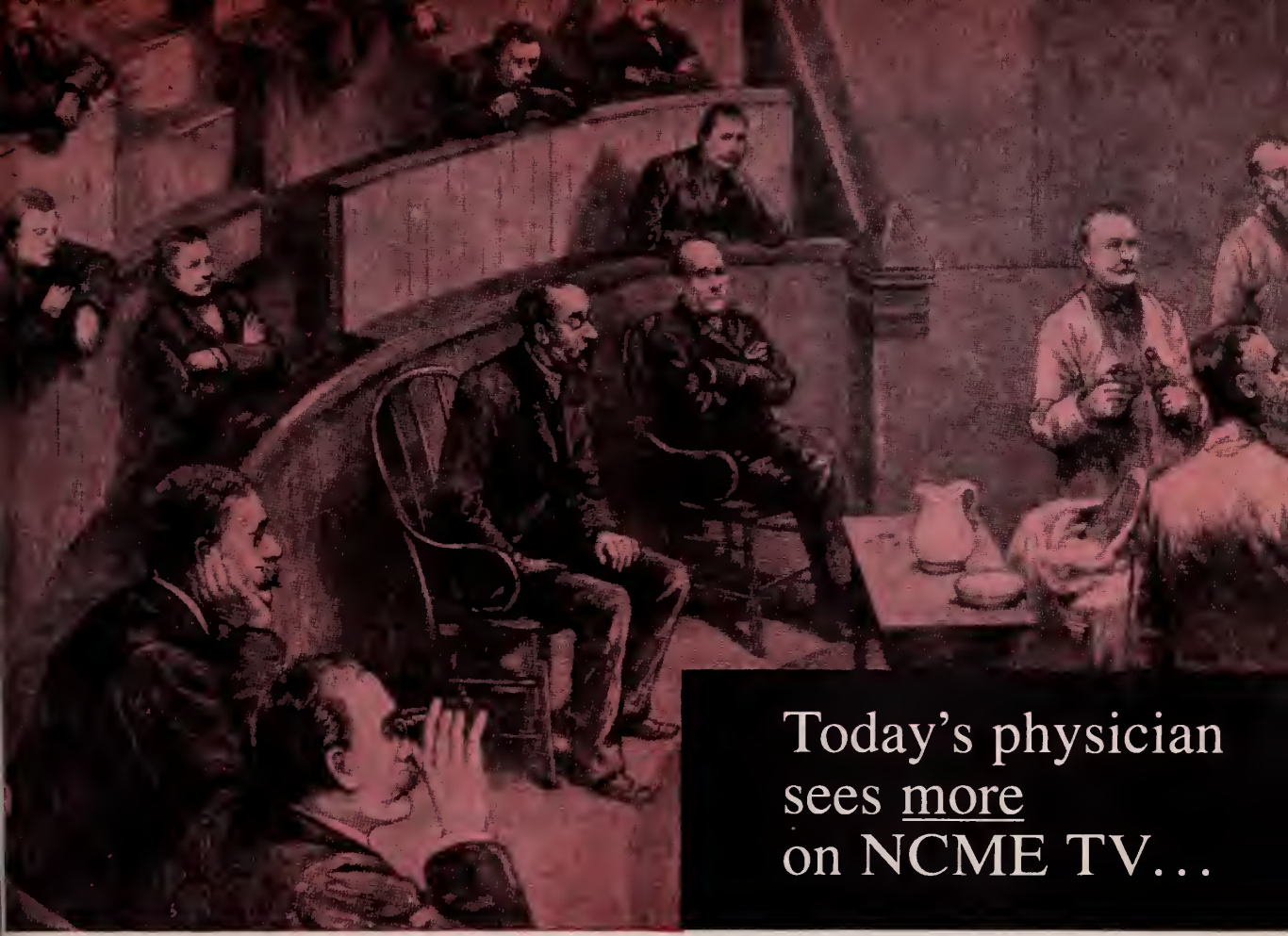
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Methyl Testosterone	2.5 mg.
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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. **DOSE** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**. In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
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Methyl Testosterone	2.5 mg.
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Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
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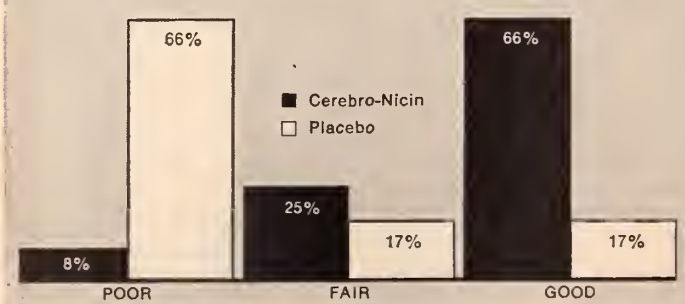
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient. R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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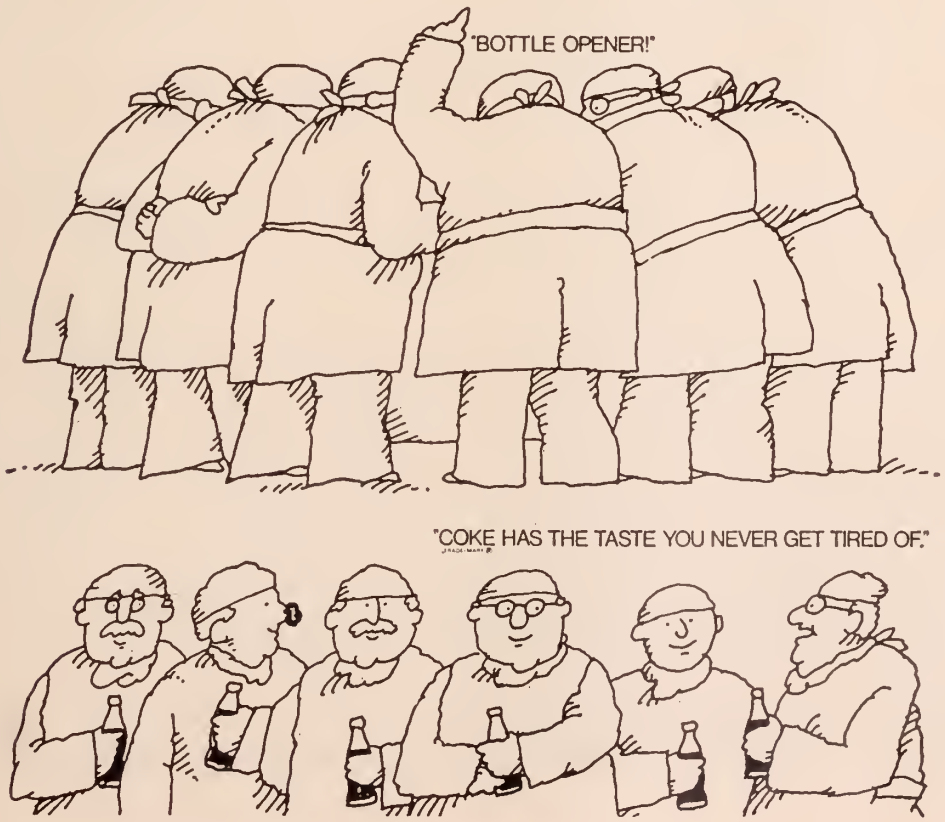
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Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

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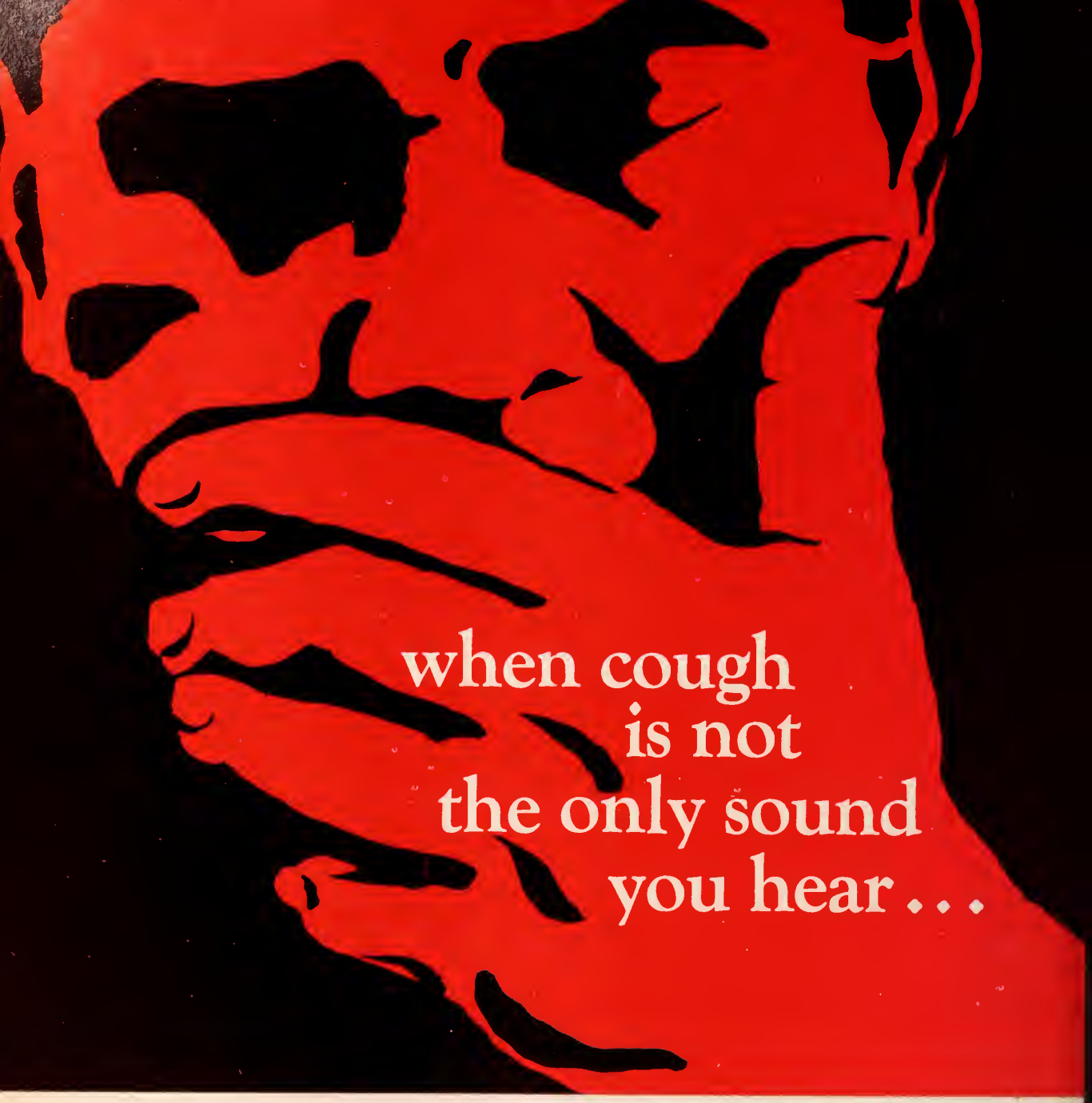
SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J Ralph et al Clinical Medicine 70 547 (Mar.) 1963 2 Isenberg, Henry D Health Laboratory Science 1 185-256 (July Aug 1964) 3 Isenberg Henry D Health Laboratory Science 2 163-173 (Jan 1965)

TAO® (triacetyl-
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is a macrolide antibiotic, for use only in
the treatment of acute severe
infections where adequate
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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

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Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
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Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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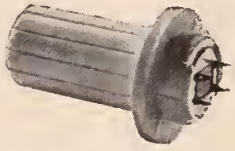
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He says "It's my stomach..."



...but his other symptoms:

functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

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when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

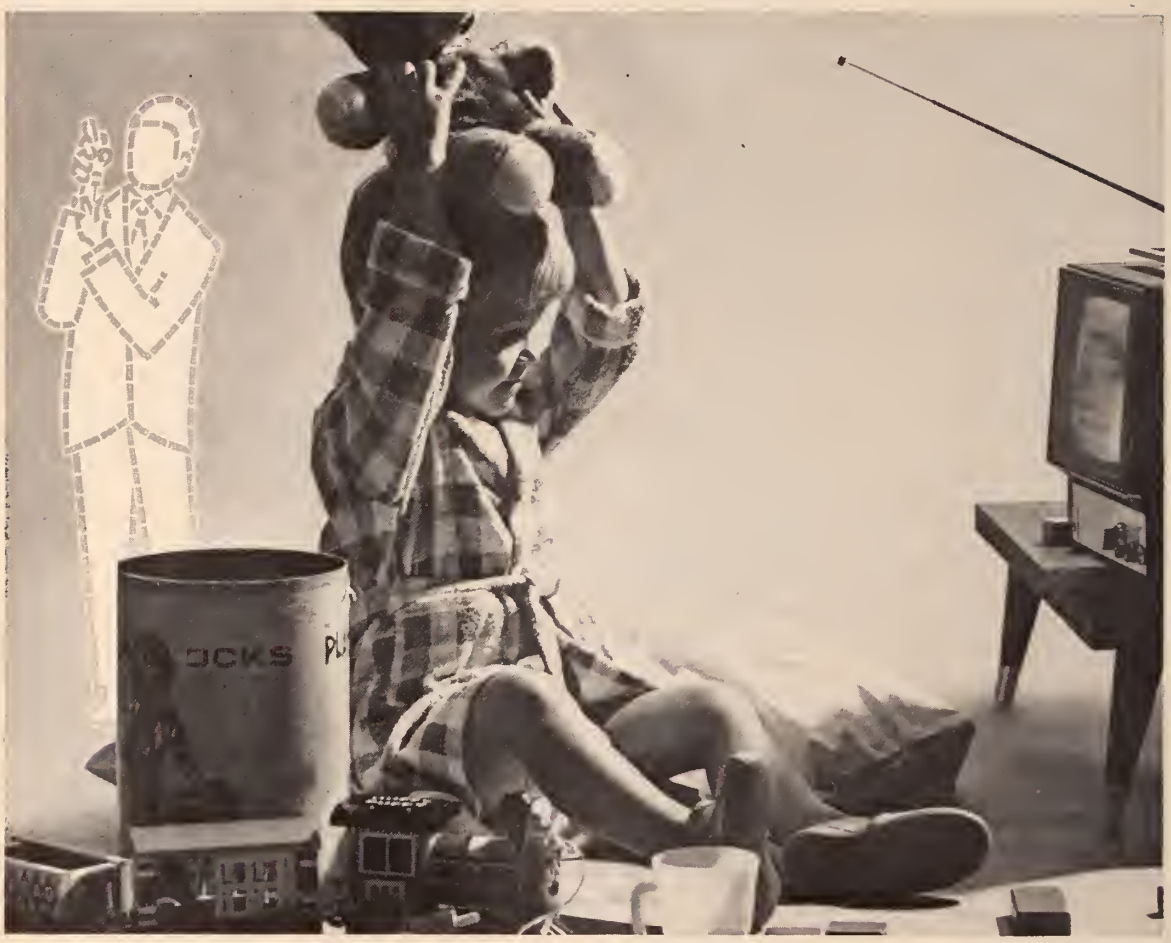
Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

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EDITORIALS

The University And The Medical Student

Today, some 90 per cent of all American medical schools are university-affiliated. Sometimes the affiliation is a loose one; sometimes the medical college is an organic part of the university. There is a growing disposition to believe that the best of medical teaching can come only in ivy-covered buildings. This has led, however, to increasing emphasis on research and on "pure" (as opposed to "applied") scholarship.

The most eloquent presentation of the university-centered viewpoint is expressed in Dr. Lowell Coggeshall's report to the Association of American Medical Colleges. As Dr. Coggeshall sees it, the university hospital has become a "referral" hospital, the implication being that serious illnesses go there, letting the community hospitals take care of easy or minor disorders. "Research," he writes, "is an essential ingredient in the preparation of the young physician" and research, he implies, is better in a university-based program. The student should be taught, he thinks, to understand the biochemistry, histopathology, and the processes of disease rather than to accumulate facts. It is as if the emphasis was to be on mechanisms rather than people. Dr. Coggeshall also believes that the university, not the community, (through its hospital) should take responsibility for intern training. He even suggests that if our medical schools do not embrace university sponsorship soon, the government will take over.

Emphasis is also on the team concept—bringing into responsibility the microbiologist, the mechanical engineer, the physicist—all of whom have contributions to make to research. Another problem in today's practice, as he sees it, is "an armamentarium for the use of the physician that is beyond belief in its capabilities and cost"—the suggestion being that only a university budget can afford such equipment! In the last 30 years, the proportion of MD's in solo private practice has tailspinned from 86 to 63 per cent. You don't have to be a university professor to figure out that before long there will be more physicians on salary than in solo private practice. Dr. Coggeshall has yet another warning: if the universities neglect their responsibility (in developing medical schools) we will see the reemergence of schools "of marginal quality." There is here the hint that the extramural medical schools are necessarily second rate.

Most of us think that smaller classes are better than the thousand-seat auditoriums for medical teaching (sometimes, medical preaching) that characterize schools in some parts of Europe. Dr. Coggeshall, however, suggests that the larger schools could be better because of their large supply of "clinical material" (a euphemism for patients) which, it seems, he thinks is more important than closer study-faculty relationships. "Some of very best qualified physicians have come from larger schools: some of the graduates of the small schools are among the least well prepared." (One assumes that the professor of statistics would have flunked any student who tried to prove anything by *that* generalization!)

One advantage of a university-based medical school is that it would help the doctor's collaboration with "social scientists, economists, community planners, psychologists, engineers, and anthropologists to provide for society the entire range of available preventive and therapeutic measures." Dr. Coggeshall points out that, "the MD degree is earned at about the midpoint of the formal education of the physician. The doctor is not fully qualified to practice at this point, but here the traditional medical school relinquishes its responsibility. Professional physician education should continue under the sponsorship of university medical schools." The university medical school, he says, should provide programs and leadership; "it should be the responsibility of the university to indoctrine students in the need for continuous educational renewal . . . the influence of the university should extend beyond the campus to support the practitioner throughout his career. . . . inter-

disciplinary approaches to instruction and research can be taken best, and probably *only,* within the jurisdiction of the university . . . the university alone can encompass the education required for *all* the health fields . . . only through the university can the full benefits of scientific advance be brought to the physician."

What Price A Life?*

It cost community hospitals an average of $58 to provide a patient with a day of care in 1967. This was 15 per cent higher than in 1966 when the average cost was $50. Wages and salaries account for $36 of the present per day expense as compared with $30 in 1966. Hospitals on the average now employ 264 persons for each 100 patients. Twenty years ago the ratio was 148 per hundred.

At one time the operating room was the technical center of the hospital. Today there are other technical enclaves beside the operating room—the clinical laboratory, the blood bank, the recovery room, the intensive care unit, and the cardiac care unit. All of these refinements are essential to any hospital that serves as a medical center for its community. They require specialized staff and equipment unavailable ten years ago.

One recently installed intensive coronary care unit, consisting of eight beds, requires twenty-four-hour coverage by cardiologists, a specially trained group of 18 nurses, and most sophisticated electronics equipment for monitoring the patient to provide instant diagnosis and treatment of complications that may arise.

In addition to heart rate, pulse and pacer monitors, and an oscilloscope, all ceiling-hung, each bedside has an electrocardiograph machine and defibrillator and pacemaker equipment. Portable monitoring units at each bedside, connected to the central station, show systolic, diastolic and venous pressure, and temperature.

Central nurses' station equipment can continually monitor any two patients' physiologic pressures and temperatures at one time. A console at the station displays all patients' electrocardiograms on individual monitoring oscilloscopes and pulse rate meters. The central station will monitor on a continuous basis each patient's electrocardiogram and constantly stores this information for the current forty-second period on a magnetic tape cartridge.

Should signals of distress from a patient be displayed on the monitoring equipment, an alarm button will sound at the nurses' station in addition to a light signal of distress, sending a medical-nursing team to a stricken patient's aid in seconds. If more are needed, the nurses' station has a "panic button"—to summon help from an adjacent patient care unit in the hospital. In the event of an alarm condition, the ECG information about a patient stored on the forty-second tape cartridge will be printed on the central station electrocardiograph machine.

In addition, patients' physiologic information from each bedside can be switched to a display, recording, and data storage system in the adjacent treatment laboratory. The information may be recorded on an eight-channel optical recorder, presented on an eight-channel oscilloscope, and/or recorded on a seven-channel, three-speed analog magnetic tape recorder. The tape recorder can play back at the recorded speed or an increased or decreased speed for screening; selected sections then can be printed. The tape recorder also can be programmed to record automatically patient information every fifteen, thirty, or sixty minutes for one-minute periods.

This dream of science fiction is no longer fiction. It is actually saving lives in our hospitals.

Similar technologic advances are in actual use in all departments. They are bound to raise the cost of hospitalization, but they lower the mortality rate. Which way does the community want it?

* From the June 1, 1968, New York State Journal of Medicine.

ORIGINAL ARTICLES

We have developed marvelous means to save or prolong life. We still need to develop an answer to what we are living for.

Medicine, Religion, And The Ethos*

John S. Madara, M.D./Salem

We live in a peculiar age—

At one end of the spectrum of life, we have found ways to prevent conception and terminate pregnancy with clean hands and a pure heart; at the other end, we have learned how to keep a body alive beyond its years of usefulness.

Between these extremes, we save lives by miracle drugs and technics, but we do little to prevent self-destruction by nicotine, psychedelics, alcohol, and the automobile.

We have more leisure time than ever, and more ways of spending it; but many people are full of anxiety, or bored to death. We denounce violence but we condone public nudity and homosexuality.

We create a new morality to satisfy old desires.

College students demand permission to share a common room, but accept no responsibility for the outcome of that relationship.

We have seen a black man's heart keep a white man alive, but we haven't found a way for both of them to live together.

The once-accepted dictum that life begins when sperm meets egg has been changed to justify the use of the intrauterine contraceptive device; the old-fashioned idea that a person dies when his heart stops has been modified to allow the transfer of a beating heart from one body to another.

In short, we fit our means to fulfill our ends. Some of these modifications of modern medicine may be justified — some may not. That's the purpose of our Symposium on Medicine and Religion: to discuss the moral implications of the scientific advances of our age — truly an age of medical miracles, but also an age of religious rebellion. I've asked our panelists to give some thought to some of the basic problems facing religion and medicine, such as —

1. Birth control and the liberalization of sex and abortion.

2. The use of drugs for pleasure.

3. The cause and management of the rise in crime, delinquency, lawlessness, and violence.

4. The prolongation of life and the morality of organ transplantation.

5. The definition of death, and the beginning of life.

*Opening remarks, introducing the Symposium on Medicine and Religion, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 19, 1968.

31 Market Street

Chaplain Boone here highlights the urgency of joint thinking and acting between physicians and clergymen.

Religion And Medicine: Some Ethical Issues*

William J. Boone/Montclair

Clergy cannot presume to be authorities who hold the answers to the multi-faceted ethical and religio-medical questions which modern medicine raises. On each matter it is necessary to have situational and empirical concerns brought *via* the physician so that a common enterprise of discussion and dialogue may take place to grapple more creatively with such significant concerns. Too often in the past the burden of responsibility has been transferred by physician to clergy or clergy to physician and the two have not really communicated with each other.

It should be stated that there is no Protestant position, as such, on any of these issues. Rather there are manifold Protestant positions which reflect the diversity of Protestantism itself. What I propose is a very general Protestant view with which some Protestants will sincerely disagree. With this in mind the following generalizations are offered.

Most Protestants encourage planned parenthood and birth control, from the standpoint of the welfare of the child, parents, family, and society. They do not see any ethical difference in the methods by which this is achieved since the basis of this ethic is not wedded to a view which says that an interruption of the process of nature or natural law is immoral. Such a rationale also carries over into the area of abortion where it would be sanctioned in certain situations, after sober judgment by medical authority indicated that this procedure would be salutary for the life of the mother or her emotional stability, to cite only two conditions.

A real question can be raised as to whether there is a liberalization of sex in contemporary society. There is certainly much more candor, publicity, and improved reportorial methods in apprising us of the practices, mores, and morality of our day. However, the moral fiber of our day is probably no flabbier than it was in previous generations. What may have been more of a conformist ethic in the past was probably more prudence than high ethical posture. The following limerick illustrates the point:

> "There was a young lady named Wilde,
> Who kept herself quite undefiled.
> By thinking of Jesus and social diseases
> And the fear of having a child."

The challenge before us today is to meet the breakdown of an older ethic of prudence which is no longer listened to by a new generation and which medical science has made obsolete and irrelevant by "the pill" and penicillin. We must take up the slack by formulating and communicating a relevant situational ethic of love, not fear or prudence, which recognizes the complexity and relativity of the existential situations facing people today. Authoritarian rules of conduct which do not take cognizance of the human situation, and prudence based largely on fear, just will no longer do.

This same applies to the use of drugs for pleasure as well as delinquency. The prob-

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lems facing people in this area are of a nature which require not only solid ethical formulation, but an examination of the dimensions of emotional maturity and personal and inter-personal meaning. Some of contemporary behavior can be seen as healthy rebellion and protest against the irrelevance and the duplicity of the ethical postures of an older generation, and a search for a new identity with greater moral fabric, while some remains an expression of the poverty-stricken, self-destructive pathology which is characteristic of the alienation of contemporary man.

To my knowledge, Protestantism does not view the prolongation of life as an ethical good. Quality rather than quantity of living is the focus of ethics and the Christian life. Few would, therefore, object to restricting keeping people alive *via* extraordinary means. Little moral good is served by prolonging life through artificial means and much human debasement and unnecessary suffering can accrue. Moreover, many Protestants would argue that to prolong life artificially is fundamentally immoral because it denies a person of his ethical right to die. And still others would advocate voluntary euthanasia under certain circumstances and with a medical-lay panel evaluating and judging such a patient's request.

On the surface, organ transplantation raises no moral strictures and more significantly commends itself as an act of altruistic love. However, grave moral questions are raised when consideration is given to the timing of removal of organs (definition of death), who will receive the organ, who will bear the expense, who will prevent the hoarding of organs so that equitable distribution can be made. Physician-lay panels may be required to evaluate and make judgments in particular situations in this area while an agency of control, possibly national in scope, will need to be considered to prevent blatant abuses of organ availability and deal with the complex financing of such.

In trying to define death, the theologian must defer to the physician for the most part. Here, as in many of the issues described above, the need for close collaboration in making ethical or any kind of decisions are most dramatic. The theologian must depend upon the physician for empirical data, while the physician can be assisted by values and existential questions posed by the meaning of death in a specific situation. A new and consistent concept of death is demanded, particularly with the availability of organ transplantation. At this juncture, it appears no absolute definition which covers all circumstances can be offered. Some medical authorities indicate that death can be pronounced when brain function has ceased, antecedent to the death of cardiac function; but this is not entirely definitive. Most authorities agree that "heart death" and "brain death" must be observed before an organ is removed. The awesome fact remains that the life or death decision is partly intuitive and will have to be made by the physician. The question remains: should such a decision be left in the hands of the professionals? In large measure it will have to remain there because of its empirical nature. Perhaps some physician-lay panels may be organized in communities and hospitals to avoid a shirking of moral responsibility by placing the awesomeness of this decision all on the shoulders of the physician.

In this, as in the other areas only touched on above, the challenge of medical science and the revision of morality in contemporary society demand new concepts, new ethics, and a new partnership of medicine and religion in dialogue with each other.

The Mountainside Hospital

Here is briefly sketched the liberal Jewish viewpoint on transplantation, abortion, the time of death, and birth control.

Judaism And Some Modern Medical Problems*

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We live in a secularized society. This means that the ideologies of secular society have attained the stature and sanction formerly reserved for religious ideals and practices. When we speak, for example, of "democracy" we do so with reverence and with the implications of an almost metaphysical mystique. In the light of this reality a discussion of "Religion and Medicine" would address itself to three areas of concern:

1. The search for sanction or support from the religious sector for the practical application of medical technological advances.

2. Coloring the context of scientific endeavor with the idealism customarily ascribed to institutional and personal religion, thereby looking upon science as functioning under a "higher law."

3. Recognition of the clinical relationship between religion and medicine through postulating the therapeutic role of institutionalized religion and its functionaries. In other words, giving religion its functional and rightful place in the scientific world.

In these comments I present the Jewish point of view. Although I will try to be objective, it is of necessity *my* Jewish point of view, which is admittedly liberal (as contrasted with orthodox). Judaism is the least dogmatic of traditional western religions; yet there *is* a general consensus among most interpreters of Judaism as to principles. There is a Jewish law, derived basically from the Talmud. And where we may no longer follow the letter of Talmudic practice, we seek its spirit and intent as a guide.

In a sense Judaism has always been a secularized religion. It is this-worldly. It deals with the functional application of its beliefs within society. Above all, Judaism is humanistic. Whereas some religions have conceived of God as a man-like being, Judaism conceives of man as a God-like being. Therefore, human life — and all life for that matter — is sacred. (Note the very restrictive and regulative attitudes even toward animal slaughter and meat consumption).

Being both humanistic and pragmatic, Judaism is very much in tune with the ethics of contemporary American society. That is to say that its philosophy of life and of man fits into the operational context of our ideologies. We might paraphrase the Jewish approach by saying: Man is really the measure of all things, not because he is man, but because he is the closest we can come to God.

At this time I will address myself to three current issues. We are not looking here for absolute answers but rather for a posture; a position which will help us arrive at situational solutions. These issues are: birth control; definition of death; and transplants.

(1) Traditional Judaism discouraged birth control. The first command issued to Adam and Eve was "Be fruitful and multiply." As a jocular theologian put it, with some justification, "Judaism did not aim its concern at the apple on the tree but rather at the tomato on the ground." As in many other traditional practices the commandment of fruitfulness devolved more upon the male than upon the female. Therefore, wherever permissive at-

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titudes toward birth control were expressed — which indeed was always the case where bearing a child would present physical or mental hardship to the mother — it was expected that the controlling measures would be taken by the woman, for whom mechanical inhibition of fertilization is permitted. The tradition considers it desirable for a couple to at least reproduce itself, yet intercourse is looked upon as more than a procreative function. It is considered an expression of love and spiritual union. This is evidenced, among other things, by the implication that a man must provide coitus for his wife even if she is known to be infertile. Even premodern Judaism had a liberal approach to contraception where birth was potentially dangerous to the mother's life or well being. The rhythm method is virtually ruled out in Orthodox Judaism since physical contact during the immediate post-menstrual period is prohibited. For the average Jew of today birth control by any means is universally acceptable. Prevention of conception is not considered destruction of life.

(2) When does life begin and when does it end? Life begins when fetal movement can be discerned. Not having stethoscopes, the ancients understandably used this criterion. Nevertheless, an infant even after birth, is not considered a fully viable being until it is thirty days old. This is demonstrated by the fact that no mourning rites or burial rites are required for a stillborn or for an infant less than thirty days old. Respectful interment in a Jewish burial ground, however, *is* required. This is even true, wherever possible, of severed limbs and excised organs. On the question of saving a mother or an unborn child there is no debate. The child should be aborted. It is always the more viable life that gets the preference if a choice must be made. By implication (and interpretation) permissiveness in therapeutic abortion could be extended to other valid exigencies—where there is danger to life or health; or if the birth of the fetus would bring excessive mental anguish to the parents or to the child itself. Once the fetus has reached the point where it would live if born, its destruction is the taking of life.

(3) The definition of death and consideration of transplants go hand in hand. The definition of death is not limited to the stopping of the heart. If medical knowledge defines extensive and irreversible destruction of the brain as death (even though the heart tissue is viable) this should be accepted, just as prior to today's medical knowledge, the stopping of the heart was considered death although the brain may have been "alive" for some minutes. Regarding transplants, the basic principle that has operated in Judaism is that there is to be no mutilation of the dead. The deceased is considered a defenseless being and is therefore inviolate. This is the basis of the vehement objection which traditionally oriented Jews have to autopsy. However, as in so many other instances of Jewish practice, the sanctity of life, and the need for its preservation, override religious law. Thus if so-called mutilation of the dead is of immediate or provable benefit to the living, the use of a cadaver's organs is permissable. The Rabbinical Assembly, representing the Conservative Rabbinate, has already ruled in favor of eye donations for corneal transplants on this basis.

We would do well to conclude these considerations with the old rabbinic commentary on the creation of Adam which bears out the Jewish attitude toward human life. Why, it is asked, did the Almighty create a single man, when in His omnipotence he could have populated the whole world. Man was created as a solitary being to teach that he who saves or preserves one life is tantamount to having saved the whole world. Conversely, he who destroys one life is considered as having destroyed the whole world.

Temple Beth Ahm

One of our basic dilemmas is to give a potent drug out to prevent side-effects. Here are some useful suggestions about the widely used psychotherpaeutic drugs.

Side Reactions To Psychotherapeutic Drugs

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Side reactions to drugs are the price which must be paid for effective treatments. If possible, side reactions should be avoided. When this is impossible, they may require treatment, but in general, try to avoid treating one drug with another.

Some side reactions require no treatment, being mere nuisances. Others cannot be treated and may be fatal. Our theme in this review will be to emphasize the avoidance and conservative management of most side reactions which may merit treatment or concern.

Risks of drugs must be constantly weighed against potential benefits. Thus, among psychotherapeutic drugs, the risk of severe, often fatal, hepatocellular jaundice from iproniazid was greater than any presumed avoidance of suicides in depressed patients, so the drug was withdrawn. On the other hand, the infrequent and self-limited cholestatic jaundice associated with phenothiazines was an acceptable hazard in view of their great benefits. A number of drugs have been weighed in this balance and have been found wanting; their removal from the market has in no way impaired treatment. As risks may differ for individual patients, the conscientious physician must always make such an appraisal prior to prescribing.

Adverse Behavioral Reactions

Although we commonly think of these drugs as improving mood and behavior, for some patients it works the other way. Patients with a past history of depression or suicidal attempts should not be given reserpine, even for hypertension. Psychotic patients with retained insight and many somatic complaints do poorly when treated with phenothiazines; the unfamiliar autonomic side reactions and type of sedation create an adverse somatopsychic reaction. Phenothiazines and the tricyclic antidepressants may produce toxic-confusional states, especialy if early treatment is vigorous. A mildly depressed patient who becomes psychotic during treatment with imipramine or amitriptyline may very well be reacting to the drug. Even though most antipsychotic drugs calm patients, some produce more restlessness than others; these include the so-called "stimulating" phenothiazines of the piperazine subtype, such as perphenazine, fluphenazine and trifluoperazine; reserpine; and haloperidol. With antidepressants, almost every practitioner has had the experience of seeing a retarded depression converted to an agitated depression during treatment with ordinary stimulants or some of the monoamine oxidase inhibitors (MAOI), such as isocarboxazide, phenelzine and nialamide.

The first rule in managing side reactions is to be alert to them. The behavioral area is one in which recognition of adverse drug effects is particularly difficult.

Patients differ in their reactions to common sedative drugs, some becoming oversedated by doses that scarcely affect another. They also differ in the development of tolerance to these sedative effects. And patients may be on several central depressant drugs simultaneous-

ly, suffering from chronic iatrogenic overdosage. As a rule, it is well to administer initial doses of any sedative drug at a time when little harm can come from over-sedation, such as when the patient is spending a quiet evening at home. Once reaction to the drug and sensitivity to dose have been established, one can better gauge the amount of impairment he may suffer when the drug is being used chronically. Even so, it must be remembered that most sedative drugs in use have rather long biologic half-lives and that the possibility of cumulative effects is always present especially if doses are given frequently. Our preference is to administer the major dose of sedative drugs at night, utilizing the concomitant hypnotic action, with smaller *ad hoc* doses during the day as symptoms demand. There is little rationale for the customary routine dosage schedule with drugs such as these. Despite such precautions, we can never be sure that patients on such drugs are not impaired, especially as they function in the real world and not in the testing laboratory. On the other hand, they could be more impaired if their emotional disorder was untreated.

Habituation and development of withdrawal reactions are rare with antipsychotic and antidepressant drugs, but always potential complications with sedatives and antianxiety agents. Some with very long half-lives, such as chlordiazepoxide or diazepam, are not very likely to produce withdrawal reactions, but with diligent abuse, any drug which has the usual properties of ordinary sedative or anti-anxiety agents may do so. The physician can prevent abuse of these drugs by prescribing them only for comparatively short spans of time broken by periods without drug, as well as by limiting the total amounts. When abuse has occurred, the most satisfactory treatment is a gradual weaning from the drug involved.

While suicide may not be thought of as an adverse behavioral reaction, it is actually the most dire, even though more a function of the patient than the drug. Rarely can a patient successfully commit suicide with phenothiazines or with the benzodiazepine drugs, such as chlordiazepoxide. Unfortunately, most other anti-anxiety and antidepressant agents may be used as suicidal vehicles. Thus, amounts of drugs prescribed at any one time should be limited to sub-lethal amounts. The management of overdoses with these drugs has been reviewed elsewhere.[4]

Central Nervous System Reactions

Extrapyramidal syndromes are unique complications of antipsychotic drugs. Possibly the most frequent manifestation is akathisia, or the inability to remain at rest. Sometimes this symptom is very difficult to distinguish from restlessness associated with psychosis. If it is true akathisia, a test dose of an anti-parkinson drug, such as benztropine methane-sulfonate, may provide temporary but immediate relief and thus aid in the diagnosis. Sustained treatment with such agents may be of help, as well as the addition of a barbiturate. If the symptom is still troublesome, a switch to another drug may be in order. Usually patients prone to develop parkinsonism (as a reaction) do so with most other antipsychotic drugs, with the exception of thioridazine, which is least likely to evoke such reactions. One deplorable policy is the routine use of anti-parkinson drugs in all patients receiving antipsychotic agents. The prevalence of clinically important parkinson syndrome is about 15 per cent. Routine treatment means that 85 per cent of patients are receiving a gratuitous drug which may produce severe complications, such as mental confusion or peripheral anticholinergic effects, in its own right.

The hazard of acute dystonic reactions from the more potent phenothiazines is especially great for young patients. Children who receive such drugs as prochlorperazine for relief of vomiting are most susceptible, but the reaction may also occur in young adults receiving phenothiazines for psychiatric treatment. If initial doses are large (or given parenterally), the hazard is increased; the treatment of the neck-face-tongue syndrome is intravenous injection of benztropine methanesulfonate, 2 milligrams usually being adequate to reverse the reaction. Caffeine sodium benzoate, diphenhydramine and sodium phenobarbital

given parenterally are also said to be effective. Most reactions are easily treated and short-lived, but some are severe and a few have been fatal. The latter are characterized by marked dystonia, disorientation and a peculiar electrolyte disturbance with profound hyponatremia, shock, and death. With conservative initial doses of phenothiazines, as well as avoiding too sharp a rise in daily doses, this complication should be completely preventable.

Recently, clinicians have become concerned over the late appearance of dyskinesias manifested by choreo-athetoid movements which do not cease after all drug has been stopped.[5] Many of these are difficult to distinguish from the mannerisms of psychosis or those of elderly edentulous patients. Still, enough cases have been reported to suggest an association with drug therapy. In the light of even some question about the validity of the syndrome, and a complete lack of knowledge of the underlying pathology, no specific treatment is available. One would assume that the most conservative possible approach to drug therapy would be in order once this syndrome becomes clinically apparent.

Seizures occurring in patients without a previous history of convulsive disorder may occur after the antipsychotics and tricyclic antidepressants. After acute and chronic treatment, hypersynchronization and occasionally dysrhythmias are seen on the electro-encephalogram. These effects are far more common than overt seizures. The occurrence of "fits" is dose-related and especially likely to follow aggressive treatment with high dose phenothiazines. As the latter are often used for their sedative effects, should seizures supervene it would seem reasonable to reduce the dose of phenothiazine and add doses of phenobarbital, an excellent sedative and anticonvulsant.

Under treatment with phenothiazines, patients may become poikilothermic. As a result, body temperatures decrease. But when high ambient temperatures exist, heat cannot be dissipated and heat stroke may occur. During excessively warm weather, patients on these drugs should be carefully watched for the development of hyperthermia and vigorously treated at the first sign. A number of bizarre neurologic syndromes have been ascribed to antipsychotics, often in patients with pre-existing brain damage. While not an absolute contraindication for these drugs, one should be cautious in using them in patients with known brain damage.

Reactions Involving the Autonomic Nervous System

Most autonomic effects of phenothiazines are anticholinergic: tachycardia, dry mouth, blurred vision, pallor, difficulty in urination and constipation. Of these, dry mouth and blurred vision seem to bother patients most. The former often leads to excessive water intake, so much so that one may consider the diagnosis of diabetes insipidus. After chronic treatment, the oral mucous membranes may become dry, glistening, friable and atrophic. Pilocarpine has been administered to enhance the flow of saliva, but generally, one would prefer to simply let the patient suck some hard candy, such as lemon drops. Blurred vision (though it may be reversible) may best be managed by corrective lenses, as the loss of accommodation mimics prebyopia. Tricyclic antidepressants are strong anticholinergic drugs capable of producing the same complications. Often these are used in combination with phenothiazines, and even worse, with the addition of an anticholinergic antiparkinson drug. This may lead to summative effects, precipitating an anticholinergic crisis manifested by urinary retention, ileus, precipitation of glaucoma, or mental confusion.

Adrenergic blockade may occur with any phenothiazine, resulting in orthostatic hypotension if large initial doses are given. Thioridazine is especially potent in this regard, producing in addition, the complication of inhibited ejaculation. Many other phenothiazines seem to reduce libido and potency in men, but unfortunately, there is no satisfactory treatment. As MAOI are also used for treating hypertension, they, too, may produce orthostatic hypotension in patients who are being treated for depression. One

might expect that these drugs would aggravate hypertension, but it is presumed that the hypotensive effect is due to formation of a false adrenergic transmitter, octopamine, which is considerably less active than norepinephrine. The latter is still the pressor agent of choice for any severe hypotensive reaction to these drugs.

The unexpected interactions of the MAOI and a number of other drugs and foods have been extensively reviewed elsewhere.[6,7] The clinical picture is one of an acute adrenergic crisis, similar to attacks associated with pheochromocytomas and for the same reason: increased amount of circulating norepinephrine. Nervous system signs include headache, stiff neck, nausea and vomiting and sometimes, subarachnoid hemorrhage. Cardiovascular signs include tachycardia, marked hypertension, and possibly acute pulmonary edema. The treatment of these reactions is like that of attacks of pheochromocytomas; phentolamine, 5 milligrams intravenously would be the preferred drug. Chlorpromazine would be a reasonable alternative for intramuscular injection.

Due to their complementary actions, combinations of MAOI with tricyclic antidepressants may produce a syndrome of marked central sympathetic stimulation characterized by restlessness, muscle twitching and convulsions, and hyperpyrexia. If doses are controlled, the hazard is not great, but such combinations should be used only by experts.

Allergic or Toxic Reactions

Although hepatocanalicular jaundice has been associated both with phenothiazines and tricyclics, the frequency with which this complication is observed clinically has apparently declined over the past decade. Undoubtedly, many patients have subclinical transient cholestasis, evident only on abnormal hepatic tests or liver biopsy. Rare patients may proceed to a picture resembling a mild form of xanthomatous biliary cirrhosis following an attack of cholestatic jaundice. Routine hepatic tests are not of much help in detecting drug-induced jaundice, although it is well to run one of the enzyme tests, such as the serum glutamic pyruvic transaminase (SGPT) weekly during the first four weeks of treatment, obtaining other hepatic tests if this sensitive indicator becomes abnormal. Of even greater importance for detection of clinically significant reactions would be an accurate daily temperature record. Few clinical cases of jaundice occur without fever and its occurrence could be used as the basis for further investigation. If jaundice occurs, the drug should be stopped, but only in severe or refractory cases is any specific treatment required. If the jaundice is slow in clearing, corticosteroids may be tried.

Agranulocytosis is a most feared complication; the fatality rate in drug-induced cases still runs between 30 and 50 per cent. Fortunately, these cases are extremely rare. The most susceptible patient is a frail elderly woman. The vast majority of cases occur within the first 12 weeks of treatment, usually between the fourth and the eighth week. Routine blood counts are relatively useless, as the onset is most often abrupt. Daily temperature records are of great help as fever is usually the presenting sign. The reaction seems to be due to a directly toxic effect of chlorpromazine on leucocytes in specially susceptible individuals; the same mechanism no doubt applies to other phenothiazines and the tricyclic antidepressants.[8] Treatment is usually conservative, the greatest problem being the control of the supervening infection. Transfusions and steroids are of dubious value.

Allergic skin eruptions, often accompanied by fever and eosinophilia, may take a variety of forms. Diagnosis of the offending drug may be complicated when the patient is on multiple drug therapy. The best management is temporary withdrawal of all possible offending agents and the use of antihistamines. Severe reactions (such as exfoliation) may require more energetic treatment, such as corticosteroids, antibiotics and fluids. Reinstitution of various drugs previously used should be done with care and close observation. Often an apparent desensitization occurs with no recurrence of rash after the drug is restarted. Some have even successfully main-

tained patients on phenothiazines while the rash regressed, but this procedure seems to be unduly risky.

Metabolic or Endocrine Effects

Weight gain still remains a nuisance. This seems to be due to improved appetite following treatment with antipsychotics, combined with the usual high-calorie hospital diets. Small rations seem to be the simplest answer. Patients who gain weight during maturity are often vulnerable to diabetes mellitus. A number of reports suggest that this is a complication of treatment with phenothiazines, and not necessarily associated with weight gain. In some instances, the impaired glucose tolerance was reversed when the drug was discontinued. Unfortunately, these patients often need some sort of antipsychotic drug, so that complete cessation of treatment is not practical. Diabetes seems to be both a rare and mild complication which should offer no special problems in management.

Lactation, gynecomastia, menstrual irregularities, and falsely positive pregnancy tests are all part of the endocrine effects of these drugs. Their mechanism of action is largely unexplained and no specific treatment is available. The endocrine actions of chlorpromazine in animals and man have recently been reviewed elsewhere.[9]

Pigmentary Disturbances

This new heading deserves to stand alone, as there are now enough different clinical syndromes to merit separate discussion. The first such complication to cause alarm was pigmentary retinopathy due to some piperidine phenothiazines, first the investigation drug, NP-207, and later, thioridazine. With the latter, which is widely used, the development of retinal pigment appears to be dose-related. Virtually no well-documented cases have occurred at daily doses less than 800 milligrams. This dosage maximum is recommended on the package insert, and should not be exceeded without adequate justification. Once retinal pigmentation has developed, slow regression has been observed in some cases, but rarely completely. Some record of the state of retina should be made prior to treatment with any phenothiazine, followed by periodic re-examinations of the macular area where most deposits begin.

More recently, pigment deposits in the skin, as well as in the cornea and lens, have been described in patients treated with chlorpromazine and possibly other phenothiazines.[10] The prevalence of such deposits in the ocular structures has run about 25 per cent in patients surveyed after long-term treatment. Experimental evidence suggests that not only are the deposits more frequent in the eye than in the skin (usually no more than 5 per cent) but that they also develop earlier. While one may not be especially perturbed about such deposits in the skin, their occurrence in light-transmitting portions of the eye may be of great significance. A few patients have definite visual impairment, some with actual cataract formation. Most, however, may carry appreciable deposits without detectable loss of vision. Attempts have been made to treat the deposits either by discontinuing or changing drugs, by restricting exposure to light, or by use of d-penicillamine, sometimes with a low copper diet. Although some spontaneous regression over time has been shown, the additional effect of the chelating agent remains in more doubt. As the condition seems to be largely, if not solely, associated with use of chlorpromazine, it would seem wise to use this drug only for short-term treatment and use other agents for long-term maintenance. Some evidence also suggests that the complication is dose-related, so that maximum doses of chlorpromazine probably should be less than previously believed to be safe. The low-dose piperazinyl phenothiazines seem to be safe to use in such cases, not aggravating matters more.

These reactions may be due to the fact that chlorpromazine (and very likely many other phenothiazines) form a charge-transfer complex with melanin.[11] Thus, the highest concentrations of chlorpromazine in the body are in melanin-containing structures. The reaction is hastened by ultraviolet exposure,

which creates a free radical, and is therefore most prominent in the skin or the ocular structures exposed to ultraviolet. On the other hand, thioridazine seems to be activated more by visible light, which would explain the predominantly macular deposition of pigment associated with this drug. Until these issues are more settled, it would appear to be wise to use chlorpromazine only at conservative doses (probably less than 1000 milligrams daily) and for relatively brief periods, switching patients to other drugs for long-term maintenance. If the precautions regarding maximum doses for thioridazine are assiduously followed, few patients should develop retinal pigmentary problems.

Cardiac Effects

This new category also deserves separate treatment in view of its potential importance. A number of years ago, attention was called to electrocardiographic abnormalities following thioridazine.[12] The changes consisted largely of abnormal T-waves, these being rounded, flattened, lowered, cloven or inverted according to varying degrees of severity. These changes were also produced by other phenothiazines but at high doses, were quite frequent with thioridazine. Even now, the explanation for them is not clear and their ready reversibility by discontinuation of the drug, or by pharmacologic treatment suggests a benign mechanism. A few patients have been recorded to have ventricular tachycardia while under this drug and one might imagine a disturbance in repolarization contributing to the development of this arrhythmia. At the moment, one would be inclined to tolerate minor deviations but consider reduction in dose or substitution of other drugs in cases where the changes are severe, especially where the Q-T interval is considerably lengthened.

For a number of years, reports of sudden, unexpected deaths during drug therapy have been published. At first, it appeared that these might be due to activation of convulsive seizures by phenothiazines with secondary asphyxia. More recently, it appears that a more common mechanism is ventricular fibrillation.[13] As the onset is sudden and completely unpredictable, the outcome is usually fatal without any chance to offer treatment. Patients who have fainting attacks during chronic treatment should be suspected as possibly having short runs of ventricular tachyarrhythmia, in which case, the drugs might be changed.

Summary and Conclusions

The enormous value of antipsychotic drugs for managing severely psychotic patients has permitted tolerance of a wide variety of often severe side reactions. Antidepressant drugs produce similar reactions, but have somewhat less therapeutic value, so that one should be less tolerant of these than in the case of the antipsychotics. The dangers of some, such as the MAOI, should limit their use to special cases. Reactions to the antianxiety drugs available are few, the dangers being greater from their misuse, either by patients or by prescribing physicians.

Many side reactions are preventable if they are recognized early enough, or if certain modest precautions are taken. Whenever it is likely that a reaction will be only troublesome and of short duration, treatment is not required. Long-lasting or severe reactions should be treated, but in general, the most conservative methods are indicated.

Generic and Trade-Names of Drugs

amitriptyline (Elavil)
benztropine methanesulfate (Cogentin)
chlordiazepoxide (Librium)
chlorpromazine (Thorazine)
diazepam (Valium)
diphenhydramine (Benadryl)
fluphenazine (Prolixin)
haloperidol (Haldol)
imipramine (Tofranil)
isocarboxazide (Marplan)
nialamide (Niamid)
norepinephrine (Levophed)
d-penicillamine (Cuprimin)
perphenazine (Trilaton)
phenelzine (Nardil)
phentolamine (Regitine)
prochlorperazine (Compazine)
reserpine (Serpasil)
thioridazine (Mellaril)
trifluoperazine (Stelazine)

Bibliography

1. Hollister, L. E.: *New England J. Med.* 257:170 (1957)

2. Hollister, L. E.: *New England J. Med.* 264:291, 347, and 399 (1961)

3. Hollister, L. E.: *Clin. Pharmacol. Ther.* 5:322 (1964)

4. Hollister, L. E.: *Clin. Pharmacol. Ther.* 7:142 (1966)

5. Uhrbrand, L. and Faurbye, A.: *Psychopharmacologia* 1:408 (1960)

6. Sjoquist, F.: *Proc. Roy. Soc. Med.* 58:967 (1965)

7. Blackwell, B.; Marley, E.; Price, J.; and Taylor, D.: *Brit. J. Psychiat.* 113:349 (1967)

8. Pisciotta, A. V.; Keller, C.; and Hayes, J.: *J. Lab. Clin. Med.* 65:240 (1967)

9. DeWied, D.: *Pharmacol. Rev.* 19:251 (1967)

10. Greiner, A. C. and Nicolson, G. A.: *Canad. Med. Assn. J.* 90:637 (1964)

11. Bolt, A. G. and Forrest, I. S.: *Life Sci.* 6:1285 (1967)

12. Kelly, G. J.; Fay, J. E.; and Laverty, S. G.: *Canad. Med. Assn. J.* 89:546 (1963)

13. Hollister, L. E. and Kosek, J. C.: *JAMA* 192:1035 (1965)

Carrier Clinic, Belle Mead (Dr. Penick)

Mothers' Backaches And Exercise

When a steady procession of young mothers came to her, complaining of low back pain, Dr. Evalyn S. Gendel was puzzled and suspicious. These mothers all seemed unwilling or unable to complete the exercises Dr. Gendel recommended. The exercises were "too exhausting," the mothers complained.

Closer questioning revealed that none of these young women had gotten much exercise in childhood. They weren't accustomed to exercise, and didn't believe in its value. They had poorly developed abdominal muscles and weak connecting tissue. For young mothers who do a lot of bending and lifting while caring for a baby, this may be a major contributing factor to chronic, severe, low backache, Dr. Gendel reports in the Journal of the American Medical Association. (September 4, 1967)

Over a five-year period, Dr. Gendel studied 93 women aged 18 to 23 who had persistent back pain following childbirth. Thirty of these had other physical problems, such as kidney, pelvic, or orthopedic disorders that contributed to the aches. Twenty-one had emotional problems which may have been a factor, and seven were unusually obese. This left 35 whose only difficulty seemed to be poor muscle development — in every case the result of a childhood without exercise. "None of these patients, for instance, had ever ridden a bicycle," Dr. Gendel said. "Only one or two cared about dancing. None were walkers. None had ever participated in a physical improvement program on an individual or group basis." The women shared "a common history of passive activity since childhood." None were bowlers, skaters, golfers, or participated in any leisure-time exercise.

Girls need regular programs of exercise and sports participation from early childhood, Dr. Gendel said. She urged that these be developed further in schools, and that fewer girls be excused from participating. "If the findings reported here . . . are common in just this 18-to-23 age group, it indicates that a large group of young women are affected. The problem requires scientific consideration of the positive medical value of adequate physical activity for girls through sports and athletics." In the past, statements regarding girls' athletics were "emotional and defensive," Dr. Gendel said, and emphasized only the fact that physical activity would not harm them. The positive values of exercise, including its value in preventing health problems, should be emphasized, "starting now."

Modern septoplasty provides a fairly simple technic with a broad field of usefulness. And here is how it is done.

Septoplasty In Nasal Surgery*

Herbert J. Deutsch, M.D./Cherry Hill

The introduction of the septoplasty in recent years has enabled the nasal surgeon to correct many deformities of the nose and septum. This procedure can be used to correct a deviated nose, caudal deflection of the nasal septum, and nasal septal deformities in children.

Ingals,[1] in 1882, suggested the submucous resection by removing part of the triangular cartilage. Since then, many surgeons have contributed technical improvements until the standard procedure of submucous resection (S.M.R.) was evolved. Submucous resection cannot correct deviations of the caudal septum or deviations of the external nose, and it is contraindicated in children.

Goldman,[2] in 1956, introduced the septoplasty as a procedure for treating deviations of the external nose and caudal septum. He originated many technical improvements and presented the procedure as it is performed today.

The operation is performed under local or general anesthesia. The caudal septum is transfixed by means of an incision which completely separates the margin of the septum from the columella. This provides excellent exposure, and the mucoperichondrium is elevated from both sides of the nasal septum. Compartments (pedicle cartilage grafts), approximately a quarter of an inch in width, are prepared by making incisions through the cartilage which are parallel to the caudal margin of the septum. The incision extends from the floor of the nose to within a few millimeters of the dorsal margin. At least two anterior compartments are prepared and trimmed. They are repositioned in the midline. In adults, the deviated portions of the septum, posterior to the two compartments, may be resected. In children, many compartments may be prepared and replaced in the midline, and no resection of the septum is done. The anterior nasal spine may be removed or refractured and repositioned. The mucoperichondrial flaps are sutured to the first compartment by means of mattress sutures, and interrupted sutures are used to approximate the septum to the columella. The nose is packed with vaseline gauze and a firm dressing applied.

Correction of the Deviated Nose in Rhinoplasty

One of the most difficult problems in rhinoplastic surgery is correction of the deviated nose. Regardless of the type of surgery, the septal deviation has to be corrected in order to treat the deviation. The elastic cartilaginous septum will return to its original position no matter how it is displaced or repositioned. The only way permanently to change the position of the septum is through septoplasty. It can be done as an initial primary procedure or a combination with the rhinoplasty.

The S. M. R., regardless of how extensive the resection, will not change a deviation of the external nose. The latter is always the case because the caudal septum must be completely freed, trimmed, and divided into compartments. When the compartments are repositioned in the midline, the cartilaginous septum returns to the midline and, in doing so, straightens the external nose.

Correction of the Deviated Caudal Septum

The caudal margin of the septum may be dislocated from the midline and present in either nostril. This results in nasal obstruction and a cosmetic deformity, both of which can be corrected only by a septoplasty.

An extensive submucous resection would have no effect on this problem because the resected portion of the septum lies entirely posterior and superior to the deviated area.

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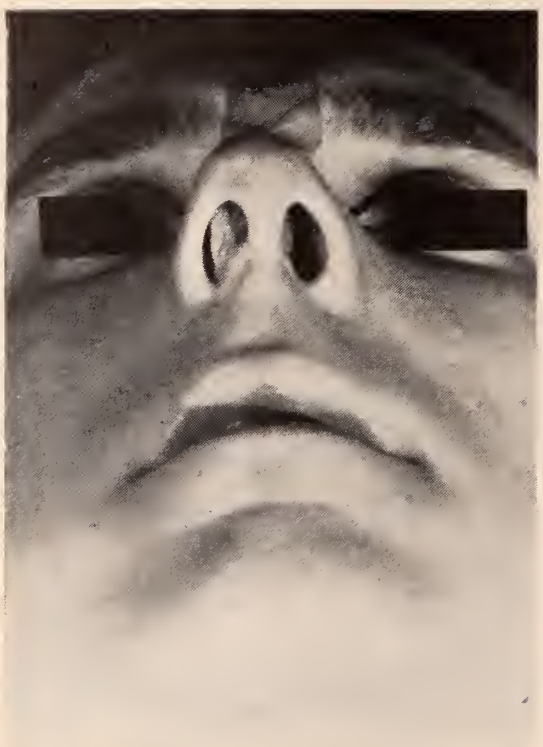


Figure 1. Preoperative photograph showing fracture dislocation of the caudal septum and complete right nasal obstruction.



Figure 3. Prerhinoplasty which was performed as a second procedure.



Figure 2. Postseptoplasty view reveals normal appearance and nasal airway.



Figure 4. Postrhinoplasty.

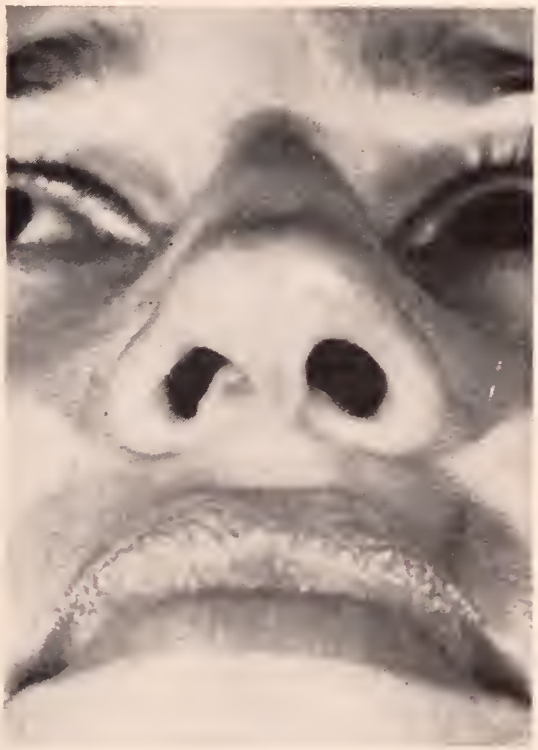


Figure 5. Preoperative photograph showing displaced caudal septum in right nostril, partially hidden by wide columella.



Figure 6. Postoperative appearance with septum in midline and normal columella. Nasal tip was corrected at the second stage rhinoplasty.



Figure 7. Preoperative photograph. The drooping tip, hanging columella, and short nasolabial fold were corrected by the septoplasty.



Figure 8. Postseptoplasty-rhinoplasty.

CHART I

Submucous Resection of Nasal Septum

1. Does not change the caudal septum.
2. Does not effect external deviations of the nose.
3. Contraindicated in children.

CHART II

Indications for Septoplasty

1. Nasal obstruction due to a caudal septal deviation.
2. Cosmetic deformity due to a fracture dislocation of the caudal septum.
3. Deviations of the external nose.
4. Nasal obstruction and deformities in children.
5. Cosmetic deformities of the columella, tip, and nasolabial fold.

When the septal compartments are constructed and placed in a midline position behind the columella, the nasal obstruction and cosmetic deformity are completely repaired.

Septoplasty in Children

Deformities of the caudal septum are usually the result of childhood injuries. The tip of the nose and columella are more frequently traumatized than the small and minimally developed nasal bones. Injuries frequently result in a fracture dislocation of the nasal septum while the bony nasal pyramid is not harmed.

If the nasal cavity is closely examined, the correct diagnosis is made at the time of the acute injury, and a closed reduction under local anesthesia may restore the septum to its normal position.

Frequently the nasal septal injury is not observed until after a few years of abnormal growth has occurred. At this stage, there is nasal obstruction and deformity, and a septoplasty is necessary to correct the problem. This is done without removing any cartilaginous or bony components of the nasal septum. As many compartments as necessary are made and repositioned in the midline.

If portions of the nasal septum are resected as in a submucous resection, there would be delayed growth of the entire nose which would result in a flattened nasal deformity. In addition, septal resection in children frequently causes a collapse of the lower nasal dorsum which results in a severe saddle deformity.

Trimming cartilage from the caudal margin of the septum will raise the columella to the level of the alar margins and correct a hanging columella deformity. The lobule of the nose is raised and the nasolabial angle elevated by shortening the caudal septum; thus the drooping tip abnormality is corrected.

Comment

For many years, surgeons tried to correct deformities of the external nose and caudal septum by modifying the standard S. M. R. The many modifications utilized were attempts to improve on the inadequacies of the S. M. R. These changes ranged from incomplete removal of the septum to total removal and replacement by grafts and implants. The modified Metzenbaum technic came closest to giving the desired results. In this procedure the initial incision was made one centimeter behind the caudal septal margin, and an attempt was made to free the caudal septum in a retrograde fashion. Because of the difficulties encountered in this way, the surgeon was rarely able to free the septum adequately and to reposition it in the midline. The mucoperichondrium would usually be elevated on one side, and the tension on the unfreed side would lead to a recurrence of the deflection. In addition, the caudal strut had to be firm and straight in order to stay in the midline, and the uncorrected deviated anterior spine prevented the caudal segment from maintaining its new position.

The effect of nasal obstruction secondary to hypertrophied adenoids is well-known in facial and palatal development. A similar influence of nasal obstruction can occur in childhood from injuries of the nasal septum.[3] Nasal obstruction secondary to septal injuries has been seen to result in an elongated face with a "languid" expression, dental distortion, an overbite, retracted upper lip, and a high arched palate. Fractures of the nasal

bones and deflections of the nasal septum in infancy and childhood should be recognized and treated at once to prevent future disfigurements.

The septoplasty provides the means to restore nasal function and correct nasal cosmetic deformities. There is no danger of subsequent saddle deformities, tip deformities, or retardation of nasal development. Nasal obstruction in childhood due to a deflected septum can and should be corrected. Usually, the septoplasty will correct associated deviation of the external nose.

Bibliography

1. Ingals, E. F.: *Tr. Am. Laryng. A.*, 4:61 (1882)
2. Goldman, I. B.: *Arch. Otolar.*, 64:183 (1956)
3. Goldman, I. B.: *Jour. Int. Col. Surg.*, 17:167 (1952)

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Advisory Committee on Health Care

Nine distinguished laymen have been appointed to a committee which advises the AMA "on present and future health care needs." The creation of this body — The Advisory Committee on the Health Care of the American People — was described by the AMA Trustees' Chairman, Dr. W. H. Hall, as "designed to open further the door of communication between physicians and leaders in other fields.

"Social and economic aspects of health care are the concern of our whole society," Dr. Hall explained, "and the AMA wants to obtain the advice and suggestions of respected representatives of business, education, religion, law, governmnt, women's organizations, labor, minority groups, publishing, and other social and professional elements."

Named chairman of the committee was the well known historian, Charles E. Odegaard, Ph.D., president of the University of Washington. Vice-chairman of the Committee is Judge Warren Burger of the U.S. Court of Appeals.

Other committee members are:

Ann Landers, author of the world's most widely syndicated newspaper advice column. She won the 1967 poll as one of the world's ten most influential women.

Charles B. Shuman, president of the American Farm Bureau Federation.

The Rev. Thomas J. O'Donnell, S.J., Director of the Jesuit Residence, a unit of the Educational and Missionary Institute of the Society of Jesus in North Carolina.

Karmit Gordon, economist and president of the Brookings Institution. Mr. Gordon served as budget director during the administrations of Presidents Kennedy and Johnson.

J. Irwin Miller, chairman of the board, Cummins Engine Co. and a former president of the National Council of the Church of Christ.

John H. Johnson, publisher and editor of *Ebony, Tan, Jet* and *Negro Digest* magazines. In 1951, Mr. Johnson was selected as one of the nation's 10 outstanding young men of the year by the United States Junior Chamber of Commerce.

Edward Swayduck, of New York City, president of Local One, Amalgamated Lithographers of America.

The rising tide of deaths from lung cancer invites further study of chemical and radiologic technics; but abandonment of cigarette smoking is still the best chance of stemming this tide.

Newer Concepts In The Therapy Of Pulmonary Malignancies*

Bernard J. Koven, M.D./Englewood

Lung cancer is reaching epidemic proportions. It was estimated[1] that over 51,000 Americans died of this disease during 1967. Of all new cases diagnosed each year, fewer than 10 per cent will survive for more than five years.[2] The majority of patients are unresectable for cure when initially seeking medical care. The five-year cure rate for localized disease is about 21 per cent; this falls off rapidly to about 5 per cent when the regional lymph nodes are involved.[3] These poor results may be attributed to the difficulty in establishing early diagnosis and the high rate of local spread and distant dissemination at the time of establishing diagnosis. In attempts to improve five-year cure rates in resectable cases, some thoracic surgeons have urged pneumonectomies rather than lobectomies or segmental resections. However, it does not appear that the success of cancer surgery varies in direct proportion to the volume of lung tissue removed.

Radiation Therapy

Radiation therapy is generally conceded to have a palliative role in selected cases of inoperable and recurrent lung cancer. Radiation therapy would not be indicated as initial therapy in operable lung cancer with the possible exception of oat-cell carcinoma. The British Medical Research Council[4] reported a carefully controlled study of 166 patients with oat-cell carcinoma which revealed no significant difference in survival in those patients treated with radiation therapy as compared to those undergoing surgical resection. The symptoms of disseminated lung cancer can often be ameliorated by radiation therapy. Improvement in superior vena cava obstruction syndrome and involvement of the skeletal system are well recognized. In addition, Chu,[5] in reporting the Memorial Hospital experience, cites a response rate of 83 per cent when brain metastases are treated with radiation therapy (ortho-voltage therapy, that is radiation delivered by a 200 to 250 KV machine, is satisfactory for treating bone and brain metastases). It is in the area of the role of preoperative and postoperative radiation therapy that considerable controversy is encountered.

Preoperative Radiation Therapy

Bloedorn[6] has been a leading advocate of preoperative radiation therapy. His rationale seems attractive: by controlling lymph node metastases inaccessible to surgical excision and by reducing local or systemic seeding during surgical handling, he feels that preoperative radiation can render inoperable tumors operable. Based upon the resected material, he states that preoperative radiation sterilizes the primary tumor in 35 per cent of the cases and the lymph nodes in 70 per cent of the cases. A dose of 5000 to

*Read before the Section on Chest Diseases, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

6000 rads is followed by surgery after an interval of four to six weeks. Other authors have failed to confirm Bloedorn's results. Mark, *et al.*[7] compared 20 patients who were subjected to preoperative irradiation with 40 who came to operation directly. Higher operative mortality and postoperative cardiac complication rates were demonstrated in the irradiated group compared to the non-irradiated patients. There was little difference in long-term survival in the two groups. Widow[9] reported a group of 65 lung cancer patients given preoperative telecobalt therapy from 1957 to 1961. He found a higher operative mortality and a survival no better than in a group of 224 cases treated by surgery alone during the same period. He felt that damage to pulmonary tissue from the radiation appeared to increase the risk of surgery. Smaller series of cases receiving preoperative irradiation have been reported[9,10,11] with equivocal results. Additional studies are continuing and it is probably appropriate to keep an open mind regarding the eventual role of preoperative radiation therapy. A special situation may exist in the superior sulcus tumor. Paulson[12] has reported favorable results in tumors arising in the upper lobe, some of which invaded the chest wall and brachial plexus. His approach is to give a mid-plane tumor dose of 3000 rads over a twelve-day period using parallel opposed fields. He follows this with en bloc total surgical resection four weeks following completion of radiation therapy.

Postoperative Radiation Therapy

Should postoperative radiation therapy be given routinely to those patients undergoing resection for lung cancer? Sherrah-Davies[13] reported 200 patients, half treated by surgery alone, the other half by surgery plus postoperative radiation to the mediastinum. Three fields of 5 by 10 cm were used giving a tumor dose of 4500 rads in three weeks using a linear accelerator. At three years after treatment there was no statistically significant difference in survival between the two groups. Bangma[14] reported a study on 73 patients undergoing lobectomy or pneumonectomy. About half of the group received 4000 rads to the hilum and mediastinum over a five to six week period. No significant difference in survival time was noted between the irradiated and non-irradiated groups. On the other hand, Guttmann[15] and Brady[16] insist that postoperative radiation is helpful in patients found to be partly or completely unresectable at the time of surgery. Until this question is resolved, I do not think we can recommend routine postoperative radiation therapy. Normal lung tissue responds unfavorably to high dosages of radiation. I, therefore, feel that this form of therapy should be reserved for the management of troublesome complications: superior caval obstruction, hemoptysis, atelectasis caused by endobronchial disease, and painful involvement of adjacent rib structures.

Chemotherapy and Lung Cancer

The most useful drugs in palliative management of lung cancer are the alkylating agents of which nitrogen mustard is the prototype. Related agents, such as Thio-TEPA, chlorambucil and Cytoxan® have been employed with generally similar results in lung cancer. Agents of this type are useful in perhaps 20 to 25 per cent of cases with wide spread disseminated disease. In addition, the rapidly-acting agents, such as nitrogen mustard and Thio-TEPA can produce a prompt response in the superior vena cava syndrome allowing for more comfortable treatment with radiation therapy afterwards. In addition, installation of one of these agents into the pleural space is often helpful in the management of recurrent pleural effusions. With this background the V.A. Surgical Adjuvant Cancer Chemotherapy Study Group[17] used nitrogen mustard as an adjuvant to surgery in resectable cases of lung cancer. Equal numbers of controls who underwent resection alone were followed. The survival experience at five years following treatment was essentially identical in both the surgery alone and the surgery plus nitrogen mustard groups. Similar adjuvant chemotherapy studies using Cytoxan® were initiated by the

V.A. group in 1962. A preliminary report[17] did not seem to indicate any advantages compared to the nitrogen mustard study.

Other categories of chemotherapy agents including the anti-metabolites (such as 5-Fluorouracil or methotrexate) and the antibiotics (actinomycin-D and streptonigran) have been less effective against lung cancer than the alkylating agents. However, there has been some evidence that 5-Fluorouracil and actinomycin-D may serve to potentiate the effects of radiation therapy. A cooperative study undertaken by the Eastern Solid Tumor Chemotherapy Group[18] employed three different protocols in treating nonresectable lung cancer. One group was treated with radiation therapy alone, a second with x-ray therapy plus 5-Fluorouracil, and a third with x-ray therapy plus actinomycin-D. The drugs were given with radiation therapy in a dosage regimen sufficient to produce definite but tolerable gastrointestinal and marrow toxicity. The addition of the drugs did not increase the ratio showing shrinkage of lesions in the irradiated field. Patient survival was not favorably affected by the addition of the chemotherapeutic agents. Recent studies indicate that hydroxyurea[19] and Cytoxan[20] may prolong survival somewhat compared to control groups of nonresectable lung cancer patients.

Summary

The addition of radiation therapy and chemotherapy to surgery for resectable lung cancer cannot be shown to increase survival significantly at the present time. However, this should not discourage further efforts to find possibly more effective dosage regimens in the case of radiation therapy or more effective chemotherapy agents in an effort to change this situation. Meanwhile, early diagnosis with efforts focused upon the high-risk patient, and anti-smoking campaigns directed at young people seem to offer the best hope in attempting to hold down the ever-climbing death rate from lung cancer.

Bibliography

1. Cancer Facts and Figures: Amer. Cancer Soc., New York, 1967.

2. Cancer Facts and Figures: Amer. Cancer Soc., New York, 1964.

3. Statistics on Cancer: *CA-A Journal for Clinicians*, 17:34-43, 1967.

4. Comparative Trial of Surgery and Radiotherapy for the Primary Treatment of Oat Cell Carcinoma of the Bronchus. Medical Research Council. *Lancet*, 7471:979, 1966.

5. Chu, F. and Hilaris, B. B.: Value of Radiation Therapy in the Management of Intracranial Metastases. *Cancer*, 14:577, 1961.

6. Bloedorn, F. G.: Rationale and Benefit of Preoperative Irradiation in Lung Cancer. *JAMA*, 196:340, 1966.

7. Mark, J. B. D., Call, E. P., von Essen, C. F.: Preoperative Irradiation in Patients Undergoing Pneumonectomy for Carcinoma of the Lung. *J. Thorac. Cardiovasc. Surg.*, 51:30, 1966.

8. Widow, W.: Pre-operative Irradiation in Lung Cancer. *Acta Un Int. Cancer*, 19:1297, 1963.

9. Faber, L. P., Kaiser, G. D., Langston, H. T.: *J. Thor. Cardiovasc. Surg.*, 46:227, 1963.

10. Jensik, R. J.: Pre-operative Irradiation and Bronchopulmonary Sleeve Resection for Lung Cancer. *Surg. Clin. N.A.*, 46:145, Feb. 1966.

11. Lawton, R. L., Rossi, N. P., Latourette, H. B. and Flynn, J. R.: *J. Thor. Cardiovasc. Surg.*, 51:745, 1966.

12. Paulson, D. L.: The Survival Rate in Superior Sulcus Tumors Treated by Presurgical Irradiation. *JAMA*, 196:342, 1966.

13. Sherrah-Davies, E.: Does Post-operative Irradiation Improve Survival in Lung Cancer? *JAMA*, 196:345, 1966.

14. Bangma, P. J. and Tonkes, E.: Value of Post-operative X-ray Treatment in Bronchial Carcinoma. *Nederl. T. Genlesk.*, 109:653, 1965.

15. Guttmann, R.: Results of Radiotherapy in Cancer of the Lung Classified as Inoperable at Exploratory Thoracotomy. *Cancer*, 17:37, 1964.

16. Brady, L. W., Conder, L., Evans, G. C. and Faust, D. S.: Carcinoma of Lung: Results of Supervoltage Radiation Therapy. *Arch. Surg.*, 90:90, 1965.

17. Higgins, G. A., Jr., and Wolf, J.: Chemotherapy and Lung Cancer—Present Status. *J. Thor. Cardiovasc. Surg.*, 51:499, 1966.

18. Hall, T. C., et al.: A Clinical Pharmacologic Study of Chemotherapy and X-ray Therapy in Lung Cancer. *Amer. J. Med.*, 43:186, 1967.

19. Kaung, D. T., Walsh, W. S., Sbar, S., and Patno, M. E.: Hydroxyurea in Therapy for Nonresectable Cancer of the Lung. Cancer Chem. Reports, 52:271, 1968.

20. Wolf, J.: Personal Communication.

Private practitioners came under social security in 1965. In addition to earning retirement protection, they may also have earned disability protection. Work credits could have been accumulated before 1965 through internships, residencies, military service, and other covered employment. This article discusses the disability program, and how recent changes in the law affect the physician and his patients.

The Social Security Disability Program

How Recent Amendments Will Affect The Physician And His Patients

Jarvis M. Smith, M.D./Trenton*

If you pay — or if you have ever paid — social security contributions on your earnings, you and your family may be covered by the social security disability program.

In the disability program, a worker under 65 may be eligible for monthly payments if he is disabled because of a severe physical or mental impairment which has lasted (or is expected to last) a year or longer. He must be unable to do not only his usual job, but to do *any work in keeping with his age, education, and experience.*

The disability program was improved by legislation that became law early this year. As a result of an increase in benefits under the new social security amendments, monthly payments can amount to as much as $189 for a disabled worker and $395 for a family. In forthcoming years, maximum monthly benefits will be even higher.

To be insured for disability purposes, a person disabled when he is 31 or older needs to have worked under social security for at least 5 of the 10 years preceding the onset of disability. For younger workers, who may not have had the chance to work this long, the work requirement ranges down with age to as little as 1½ years of work credits.

Under the new amendments, an additional group of people — disabled widows (including certain surviving divorced wives) and disabled dependent widowers of insured workers — can become eligible for reduced benefits at 50 or older, even though they themselves never worked. The disability must occur before or within seven years after the spouse's death — or, in the case of a widow caring for a child entitled to benefits, within seven years after her benefits as a mother end. Factors such as age, education, and previous work experience are *not* considered in deciding whether a widow is disabled (as they may be for a disabled worker).

Benefits begin with the seventh full month of disability. (A six-month waiting period is required by law.) Payments can last as long as the disability continues. At 65, payments to disabled workers are converted into retirement benefits without any change in amount.

Helping Your Patients

Many physicians routinely advise any patient who they think might qualify for disability benefits to consult his social security office. Such advice can be a great service to the patient. Disabled patients often have financial difficulties. Thus your suggestion that they file may result in their getting urgently needed funds.

The people in any social security office can tell a claimant what the eligibility require-

* Dr. Smith is Medical Director of the New Jersey Rehabilitation Commission of the Department of Labor and Industry.

ments are and can help him apply for benefits. If a person is unable to come to the office because he is homebound or hospitalized, a social security representative can visit him.

Up to the present the most frequent causes of disability have been arteriosclerotic and hypertensive heart disease, emphysema, schizophrenic disorders, pulmonary tuberculosis, rheumatoid arthritis, and osteoarthritis. Currently in New Jersey, about 36,322 disabled persons — plus about 15,854 dependents — receive about 5 million dollars a month in benefits under the social security disability program.

Reporting Data

When a patient applies for disability benefits, he is expected to furnish reports from his treatment sources for use in evaluating his claim for disability benefits.

Disability decisions under the social security program are made by an evaluation team consisting of a physician and a lay disability evaluation specialist. The team works in an agency of the state in which the applicant lives — in New Jersey, at the Rehabilitation Commission.

Typically, the evaluating physician is a private practitioner serving the agency on a part-time basis. He reviews the reports from physicians and hospitals and, in conjunction with the non-medical member of the team, decides whether the applicant's impairment is disabling under the law. The evaluating physician neither sees nor examines the patient. He depends entirely on the evidence reported by you and others who have examined or treated the applicant.

Experience has shown that the extent of a patient's disability can be determined largely on evidence from his own physician's records. By giving a detailed report of objective data in your files, you can help speed the decision on your patient's claim. On the other hand, long delays can result if the physician responsible for evaluating the evidence must write back to you or seek from other sources medical information about symptoms, signs, and laboratory findings that you may already have in your files.

To be most helpful, report the same information that you would send any colleague to give him a complete medical picture of the patient. This report should contain a diagnosis, a complete history, results of physical examination, and relevant diagnostic tests. You may save time by enclosing photocopies of pertinent portions of the patient's chart, including laboratory reports, electrocardiograms, x-rays, and the like. Originals are welcome and will be promptly returned if requested. Under the law, your patient — not the Government — is responsible for providing the initial medical evidence in support of his claim.

Sometimes more medical evidence is needed for an evaluation than is available in the patient's chart. In this situation, the physician evaluating the claim may ask you to do the needed tests and examinations at Government expense, or he may find it necessary to refer the patient for an independent consultative examination, also at Government expense. When the latter is done, the consultant's report can be sent to you if you wish.

Childhood Disability

In addition to covering disabled workers and disabled widows, the social security program has a provision for "childhood disability" benefits — a somewhat anomalous title since these benefits are not paid until the person reaches 18. Ordinarily, children cannot get social security benefits as dependents after reaching 18 unless they are full-time students; and then only until they reach 22. But under the "childhood disability" provisions, a person continuously disabled since *before* reaching 18 can be eligible for benefits *after* he reaches 18.

Childhood disability benefits are payable when the beneficiary's parent covered under social security dies or becomes entitled to retirement or disability benefits. Benefits can

continue as long as the "child" lives if he remains disabled. He need not himself have worked under social security.

Since 1957 the childhood disability program has awarded monthly benefits to nearly 300,000 persons too handicapped to be self-supporting. Over 65 percent of beneficiaries under this program suffer from some form of mental deficiency. Other prevalent conditions of beneficiaries under the program include cerebral palsy, schizophrenic disorders, and epilepsy.

Motivating Rehabilitation

In addition to paying cash benefits, one of the main goals of the disability program is to help restore as many applicants as possible to gainful work. At the time your patient's claim is being evaluated, he is also being considered for possible services by the New Jersey Rehabilitation Commission. Such services — which include medical rehabilitation, counseling, teaching of new employment skills, training in the use of prostheses, and job placement — are usually financed from State-Federal appropriations.

Additional resources are also provided through social security trust funds to pay the costs of rehabilitating certain disability beneficiaries. This should save social security money because in the long run the cost of rehabilitating beneficiaries is less than the expense of paying them benefits.

As the physician, you are in a prime position to reinforce the patient's interest in returning to productive work, if this is feasible. Incorporated in the social security disability program are several incentives for rehabilitation that doctors often cite to help motivate patients.

For instance, a worker on the disability rolls who returns to work despite a severe impairment may continue to get monthly benefits for as long as a year while he tries to reestablish himself as self-supporting. If at the end of this period he shows himself able to work, benefits stop. Benefits continue, however, if his attempt is unsuccessful. This helps overcome the anxiety of a beneficiary who fears all income will be cut off if he fails in his attempt to work.

As a further incentive, former beneficiaries who have recovered or returned to work get special consideration should they again become disabled. If disability recurs within five years (seven years for widows), they need not go through another six-month waiting period before benefits resume.

SOCIAL SECURITY DISABILITY PROVISIONS AT A GLANCE

- Benefits go to disabled workers under 65 and their dependents.
- A disabled worker needs credit for a certain amount of work under social security. If he is disabled before age 31, he can now be eligible for benefits with credit for fewer years of work than before.
- Widows and dependent widowers who are 50 or older can receive reduced benefits based on disability, if the spouse was covered under social security.
- Persons handicapped continuously since before 18 may get benefits under the "childhood disability" provisions when a parent covered under social security dies or becomes entitled to retirement or disability benefits.
- Benefits are payable if the disability has lasted, or is expected to last twelve months or longer or results in death.
- Benefits generally begin with the seventh full month of disability.
- Benefits for a worker are the same amount that retirement benefits would be if he were 65.
- All applicants are considered for vocational rehabilitation services.

John Fitch Plaza

Neurotic symptoms are often relieved by a simple "behavior therapy" technic here outlined.

Behavior Therapy For The General Practitioner

Edward Dengrove, M.D./West Allenhurst

It has been said[1] that the GP "should be competent to carry out the simpler forms of psychotherapy; and is, indeed, best placed to treat neurotic symptoms swiftly before faulty habits of reaction have become entrenched."

Psychotherapy is, of course, a popular method of treatment long in use. Psychotherapy, however, is now subject to heavy criticism. Eysenck[2] for instance, has shown that the treatment offered by practitioners who do *not* follow psychotherapeutic principles, is as effective as standard methods of psychotherapy — at least in terms of recovery from the symptom or the disability produced by it.[3]

Here let us suggest other, or alternative, methods of therapy which the general practitioner can usefully follow in dealing with simple neurotic reactions and behavior disorders. These forms of therapy are derived from the application of learning principles, both classical and operant, to the treatment of neurotic disturbances. They are collectively called "the behavioral therapies."

These technics constitute a break with traditional insight therapy. They treat symptoms rather than personality review and change. They do not handle unconscious dynamic factors. The symptoms themselves are considered the disease. Neurosis is defined[4] as learned behavior which is persistent and unadaptive, in which anxiety is almost always prominent, and which is acquired in anxiety-generating situations. Historically, symptoms are considered to arise by training or by trauma, by purpose or by accident, during the life span of the individual who is more or less predisposed toward them.

Included in the behavioral therapies are (1) systematic desensitization, (2) active, graded therapy, (3) assertive responses, (4) sexual responses, (5) operant approaches plus numerous others with a base in learning theory.

Systematic Desensitization and Active, Graded Therapy

These approaches require four essentials: (1) contact with the feared object, situation, or feeling, (2) a graduated approach to this contact, (3) motivation of the patient to make this contact on a regular basis, and (4) fear reduction, induced by reassurance, relaxation training, medication, distraction, or other technical means.

Systematic desensitization does these through visual imagery in the doctor's office, having the patient live through his fears and anxieties while in a relaxed state. Active, graded therapy requires contact with the feared object, situation, or feeling in a realistic manner.

Consider a woman who has had an argument with a salesman in a shoe store. First she avoids the salesman by avoiding the store, then the street in which the shoe store is located, then the area in which the street is to be found, then the town in which the area is located. Eventually she refuses to leave the house at all, unless accompanied by someone whom she trusts, and perhaps not even then. The conditioning process is like this, and the generalization of the phobic situation a frequent accompaniment to the phobic disorder. I must admit, however, that this picture is oversimplified and the explanation seems naive.

This, however, is the very point of treatment. No attempt need be made to go into the antecedents with regard to personality pattern, character structure, or early life experiences that have led this woman to being the type she is and responding in this fashion. You might well say: this is only a symptom; one must learn a great deal more of the person in order to help her. In systematic desensitization this is not necessary. The symptom is treated; not the total person, nor the personality background. For treatment purposes it is unimportant that she is a compulsive, perfectionistic individual, terribly concerned with what others think of her due to various involvements with her parents or other surrogates as a child. It is interesting to know this, but not necessary to the treatment of her condition. The patient has come for help for the pain and anguish that her symptoms have brought her, not for personality change. With regard to this last statement, however, I do have a reservation, which I will note below.

It might appear that this is a superficial approach. Since the basic personality pattern remains unchanged, the individual will only develop another symptom to take its place. After all, nothing essential has really changed. Again, this is not true. It has been my experience, in the years during which I have used this technic, that symptom substitution or replacement does not occur where the underlying base for the symptom is no longer operative. Because most symptoms arise with problems of childhood, removal of one symptom is not followed by another.

How does one go about the business of getting rid of a neurotic symptom such as this? Medication is not the way, though, of course, medicine may be a help. Behavior therapy utilizes the experimentally proved principles of reciprocal inhibition, the best application being systematic desensitization. In this procedure, relaxation is used to counter the anxiety. It is a fact that a person cannot be anxious and relaxed at the same time, nor can he be truly relaxed and state that he is anxious.

Returning to our example of the woman with the fear of leaving her home, the first session is spent in securing a history. She is asked for a list of her fears. The history is used to identify these fears, for the list must be complete. If it is not, then other fears can be added later, for as certain of the major fears disappear or diminish, others of a minor nature, which have gone unseen, come to the surface. Or the therapist becomes aware of autonomic responses which may lead to continuation of the symptom and which need to be eradicated also; the "fear of fear" sort of thing. In addition, I ask the patient to bring in an autobiography since clues to other items for desensitization may be secured from it.

With this list of fears, anxiety hierarchies are set up for each one. A hierarchy is a list of stimuli to which the patient reacts with anxiety, from the least disturbing to the most frightening. For instance, to the woman who is now afraid to leave the house, the least disturbing stimulus would be just looking out of the window or opening the door and putting out one foot. The most frightening would be talking to the salesman in the shoe store with whom she had the altercation. Relaxational methods are then taught to her, using a modified Jacobson[4,5] technic,[6] which involves the differential relaxation of various muscles groups, or relaxation by hypnosis, or by medication. Any method may be used which leads her to report that she feels completely relaxed. Only when she is completely at ease will treatment work.

As she lies on the couch, or sits in the chair, with her eyes closed and at peace with herself, the least anxiety-provoking stimulus from the hierarchy is presented to her visual imagination. She is asked to visualize herself looking out the window of her home. If she retains her composure and continues at ease while viewing this scene, she informs us by a signal that is not disturbing to her. She may have been asked to raise her hand slightly or to nod her head a bit; not enough to disturb her equanimity.

The next stimulus on the list is then pre-

sented. She is asked to view herself putting a foot out of the door. If she responds without anxiety to this, too, she is asked to view herself putting both feet out of the door. Then to walking a few steps; to view herself walking to the street in front of her house; to walking on the street as far as the house next door; and so on. With each item she must respond with no anxiety before proceeding to the next one. If there is anxiety, she is asked to view the preceding scene which she can do again with ease. At this point the session is terminated.

At the next session, the desensitization process starts with the last item which did not evoke anxiety at the previous meeting, and treatment moves ahead from there. In the interim the general level of anxiety has apparently diminished so that she can cope with further elements in the hierarchy. Transfer of the relief from anxiety in these fixed situations to real life situations occurs.

Psychological desensitization is much like chemical desensitization for an allergic disorder, wherein the patient is injected with minute quantities of the allergen and gradually exposed to larger and larger doses until he or she is able to cope with the natural environment. As a rule, there is an acceleration of progress as one moves along.

In active, graded therapy, real life approaches are made to the feared object, situation, or feeling. Consider the child who is afraid of dogs. The child is held by a trusted person who allows him to suck on a lollipop (food is used as a counter to anxiety also) and points to a dog on a leash in the distance. A little later, the child, still held, is encouraged to view a dog through a pet-shop window. Still later, he is brought closer to a dog, and later, closer still. With the pleasure of the food and the security of being held by a trusted person, the child gradually experiences a reduction of this fear. One may use pictures of dogs or toy dogs at first, gradually progressing to small, friendly dogs, then to medium-sized dogs. In the end, the child is able to reach out and touch a dog.

One must do the very things that one fears. A fear cannot be overcome by avoiding it, nor by trying to drown it out with continued medication. Medicine, while useful, is to be reduced gradually and finally discarded. Avoiding the phobic situation or object only perpetuates the fear by reinforcement of the escape response. So — while giving the patient the tranquilizer or sedative — insist that he or she make attempts toward overcoming the fears, in a graduated fashion, with reassurance, persuasion, or the strength of your presence.

The patient is not expected to attempt any activity that produces overwhelming anxiety. But he is encouraged to try tasks that are mildly upsetting, at the same time attempting to quiet himself. If the anxiety persists, he is to stop what he is doing, for this will only set him back. Instead, he is to return to doing those things that he can do without getting upset. The patient is exposed at first only to those fears he can cope with, gradually increasing contact to those productive of more and more anxiety. One can get used to almost any new situation that is approached gradually.

Interestingly, as the milder fears are overcome the more intense ones often lose their intensity and lessen, much as the contents of a gum machine diminish with the discharge of each piece of gum. The more one attempts with relaxation, therefore, the more rapid the improvement. One must keep in mind, however, that these attempts deal only with activities that produce mild anxiety. The patient must proceed at his own pace, some steps slowly, others more rapidly. He is assured that there is no reason to feel guilt or shame if progress is slow. The process of desensitization cannot be hurried by rushing into highly anxious situations. The patient is not thrown into the water and made to swim or sink on his own. At times, under pressure of need or anger, large strides are made, but this is the exception. Gradually the patient finds himself doing things without thinking about them. Sometimes only after he has completed an activity does he realize that he has done it

without apprehension or anxiety. It may even be that someone else points out to him that he has accomplished something he would not have attempted in the past.

Assertive Responses

Another counter to fear—fear of what others think of one or fear of criticism—lies in the expression of anger. Many patients fear to raise their voices to the therapist, or to swear, even mildly, or to express anger in any form. Years ago I seem to recall reading that Simmel used abreaction for "shell shock" victims of World War I. He set up a dummy and had the patient vent his rage on this hapless substitute for living beings. Similarly, the patient is encouraged to shout or scream; to swear, first without looking at the therapist, then looking at him; to smash his fist into the couch or on the arm of the chair. In effect, the patient is taught to express his anger toward the authoritative figure of the therapist. Of course, there are limits to how much can be expressed outwardly. But at least the patient can allow himself to feel the anger and not repress or suppress it. The learned freedom is carried over to real life. A cardinal criticism of psychoanalysis by friends of patients in treatment is that it changes a person so that he is no longer the "nice" (i.e. "accommodating") person that he was before he entered treatment. The patient, however, is made happier and more capable by this character change.

Wolpe and Lazarus[6] emphasize that although the most common class of assertive responses involved in therapeutic action is the expression of anger and resentment, the term "assertive behavior" is used broadly to cover all socially acceptable expression of personal rights and feelings. A polite refusal to accede to an unreasonable request; a genuine expression of praise, endearment, appreciation, or respect; an exclamation of joy, irritation, adulation, or disgust may all be considered examples of assertive behavior.

The therapist does not give much thought to personality changes in getting rid of symptoms. However, some personality changes do occur, particularly when assertive technics are employed. The woman who was afraid to leave the house is finally able to walk up to the shoe salesman, if she so desires, and give him a few well-chosen words. She no longer fears what others think of her and is able to function more freely.

Diminishing the object of fear by poking fun at it makes it easier sometimes to overcome. Making fun of one's emotional responses will do the same. The "paradoxical intention" of Frankl[7] is based upon this type of approach.

Sexual Responses

Learning to relax during coitus is another shortcut to overcoming impotence, and often, frigidity. Wolpe's method,[4] which has been particularly effective in many cases of impotence, consists of teaching the patient to relax in the act and not become anxious over inability to produce an erection. The wife is told not to expect performance on her husband's part for a while; just to caress and enjoy each other, whatever the outcome. When the man no longer feels that he is obliged to perform he discovers that he is able to do so once again. No effort is made to work through long periods of life history. Of course, there are some situations in which impotence is due to lack of love and the absence of real interest in the spouse. This, however, is another problem. It is amazing to note how many patients will respond successfully to this simple Wolpian approach within two to six sessions.

Operant Approaches

The operant approach is based on rewarding good behavior while paying no attention to unwanted acts. The wanted behavior is then reinforced with further rewards and behavior thereby shaped or modified. Punishment is confined to aversion and avoidance technics. These have little place here. These are response-oriented procedures, Skinnerian in origin. A whole body of literature has grown from its experimental application in the laboratory with animals to clinical application

with children, psychotics, and others. For example, a child fails to eat and his mother goes into a stew for fear the child will starve. She reinforces the negative behavior by forced attempts to make the child eat. In the application of operant principles, no attention is paid to the child until he eats, at which time pleasant banter may be carried on. Attention-getting is important to the child, and is contingent upon his performing the required behavior. Likewise with temper tantrums: no attention is given to the child during a tantrum, while he is fussed over when he has ceased this misbehavior.

Parents are trained to become reinforcement-dispensing agents. They are taught how and when to dispense reinforcers, both tangible and social. Cooperation and independence are rewarded, while deviant behavior is allowed to wither on the vine. In effect, parents' child-rearing practices are modified[10] to prevent the occurrence of future problems and to promote appropriate interpersonal behavior.

Other Methods

Other methods include aversion and avoidance phenomena, anxiety-relief responses, thought stoppage, flooding, massed practice, feed-back devices, role-playing, and imitation. Older methods such as interview-induced emotional responses, the use of medication, environmental manipulation, and the like are reapplied in the light of learning theory.

Behavior therapy presents a break through to another level of treatment efficiency. The G.P.'s patient has much to gain by trying out these newer technics.

Bibliography

1. Henderon, A. and Batchelor, I. C.: *Textbook of Psychiatry*. Oxford University Press, 1962, London.

2. Eysenck, H. J.: *Journal of Consulting Psychology*, 16:319 (1952)

3. Denker, P. G.: *Archives of Psychology*, 46:2164 (1946)

4. Wolpe, J.: *Psychotherapy by Reciprocal Inhibition*, Stanford University Press, 1958, Stanford.

5. Wolpe, J.: *Journal of Nervous and Mental Diseases*, 132:189 (March, 1961)

6. Wolpe, J. and Lazarus, A. A.: *Behavior Therapy*. Pergamon Press, 1966, New York.

7. Frankl, V. E.: *American Journal of Psychotherapy*, 14:520 (July, 1960)

8. Gelfand, A. M. and Hartmann, D. P.: *Psychological Bulletin*, 69:204 (March, 1968)

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Medical Film On IUD

A new medical teaching film, widely distributed overseas, entitled "Insertion and Removal of an Intra-Uterine Device (IUD)" is now available in 8 mm. sound MoviePak® cartridges for use by physicians and medical students. This was produced at the University of Washington School of Medicine, by George C. Denniston, M.D. and Walter L. Herrmann, M.D. This 11-minute color film can be used for individual instruction and also in classrooms. The film was sponsored through a grant given by the Population Council.

According to Dr. Denniston, "The film takes the audience step by step through the relatively simple procedure of utilizing this birth control device, and demonstrates ways to avoid physical harm. The film is ideally suited for medical student training in contraceptive technics." A medical pamphlet, *Care of the Patient With an IUD,* is also available. Dr. Denniston, the film narrator is the author of the pamphlet. It is available through the University of Washington Press, Seattle, Washington, 98105. The instructional film is $90 including cartridge.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 20, 1968

A regular meeting of the Board of Trustees was held at Notre Dame High School in Trenton on October 20, 1968. For your further information, detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Reuben L. Sharp, M.D. . . . Authorized a memorial contribution to the Medical Student Loan Fund in memory of our much lamented Reuben L. Sharp, M.D., who died on October 17, 1968. Dr. Sharp was a member of the Board of Trustees from 1933 to 1960. He served as secretary for three years and as chairman for two years.

Medical Panel Consultants . . . Approved the submission of the following names of three members as consultants to representatives of the Bar Association and the Attorney General to discuss amending current law to permit withholding of autopsies in accidental death where agreement has been given or is being sought for transplantation of organs:

Edwin H. Albano, M.D., Jersey City
Joseph J. Timmes, M.D., East Orange
Arthur Winter, M.D., East Orange

Health Insurance For Pregnancy . . . Directed that MSNJ's Health Insurance Conference Committee meet with representatives of the Health Insurance Council (and it was suggested that representatives of Blue Cross and Blue Shield be invited) in an effort to implement Resolution #9, which was adopted as amended by the 1968 House of Delegates. (July 1968 JOURNAL, p. 376 — maternity coverage for all females under health insurance regardless of marital status)

Audit Review . . . Approved the report and recommendations of the special committee to review the 1967-1968 audit.

Medical Defense and Insurance . . . Approved the following revised version of the Loss Control Program as presented by the Committee on Medical Defense and Insurance:

The three-fold purpose of the Loss Control Program is:

(1) By studying and evaluating actual or potential claims and complaints filed, and by reviewing the disposition thereof, effectively to process claims and to determine why they originate;

(2) By cooperating with the insurance carriers and representatives, to effect controls to reduce or prevent claims;

(3) By advising the insurance carrier's representative, to effect solution of problems of coverage and insurability for the best interests of members of The Medical Society of New Jersey.

The Loss Control Program for the administration of professional liability insurance shall be coordinated between the insurance carrier and the Board of Trustees. The Medical Society of New Jersey's Committee on Medical Defense and Insurance, under the authority given to it, shall meet with the Society's official broker for consultation on matters of coverage or benefits; underwriting problems, including insurability; review of loss development and determination of proper rates; determination of procedures for County Medical Review and Advisory Committees; and review and final determination of all problems arising at the county level. The underwriting decision of the insurability of any physician is the right of the insurance carrier. Prior to cancellation or non-renewal of insurance of any member, the designated representative for the insurance carrier shall consult with the Committee on Medical Defense and Insurance of The Medical Society of New Jersey.

When a physician insured under this program has repetitive claims or suits, his record may be reviewed by the Committee — following decision of disposition of his latest claim — for the purpose of determining whether the surcharge schedule shall thereafter be applied.

The Loss Control Program shall be effectuated by means of a Medical Review and Advisory Committee established for each component society having 100 or more doctors insured under the program. For component societies with fewer than 100 insured doctors, joint committees may be formed to represent one or more other component societies proportionately.

In conjunction with the establishment of the Medical Review and Advisory Committee, it is recommended:

(1) That the President of each component society, in consultation with the Executive Committee of his society, submit two nominations for each place on the committee. For this panel the members of the committee shall be appointed by the designated representative of the insurance carrier subject to the approval of MSNJ's official broker.

(2) That the committee consist of no fewer than nine nor more than twenty-four members, with adequate representation of specialties, including general practice.

(3) That each member be appointed for a term of three years, without limitation of terms.

(4) That, when a new committee is established, one-third of the members be appointed for one year, one-third for two years, and one-third for three years.

(5) That a member may resign from the committee, or he may be removed by decision of MSNJ's official broker.

(6) That the vacancy be filled for the balance of the term of the member thus resigning or removed.

(7) That the chairman of each committee be appointed for one year by MSNJ's official broker, after consultation with the President of the component society.

The county Medical Review and Advisory Committee is established to serve the attorney assigned to the committee. It shall have the responsibility to review and evaluate the medical aspects of claims and complaints for the purpose of determining the facts and to make recommendations as to settlement or defense.

The Medical Review and Advisory Committee, although not a committee of a component society, shall be composed only of physicians who are members of the component society and shall consider all referred matters. These matters shall include, but not be limited to, coverage, benefits, and underwriting problems, in addition to the review of actual or potential malpractice claims.

Meetings shall be arranged at the call of the designated attorney as often as necessary, but not oftener than once a month. A definite meeting day for each month shall be established for each committee.

(1) If the defendant physician in a claim is a member of the committee, he shall be excused from attending the meeting while his case is being discussed.

(2) If an emergency decision becomes necessary, either the committee chairman or someone directed by him may poll the committee by telephone.

The agenda shall be prepared by the designated representative for the insurance carrier, who shall cause to have a notice mailed to each member of the committee seven days in advance of each monthly meeting date. If no meeting is necessary, each member shall be notified seven days in advance of the scheduled date.

When a physician is sued in a county other than the one of which he is a member or in which he is practicing the suit generally will be handled by the attorney assigned to the county where it will be tried. Therefore the claim shall be reviewed, with final determination by the committee for the county where it will be tried.

Disposition of matters before the Medical Review and Advisory Committee shall be arrived at by vote of its members. The procedure for reviewing a claim with recommendation concerning the medical defensibility of the matter is as follows:

(1) The insurance carrier shall complete the investigation as soon as possible, securing copies of all pertinent records — such as hospital confinement, autopsy, death, and the treating physician's office records.

(2) A member of the committee, usually one practicing in the same specialty as the defendant, will be appointed by the chairman to act as case chairman. A complete copy of the file will be delivered to him to review. The chairman, when necessary, may arrange for a physician not a member of the committee to be temporarily assigned to the committee to serve as a case chairman.

(3) The case chairman will review the case so he will be able to answer most medical questions when the case is presented to him at the committee meeting. If additional information or material is required in order to complete the review, the case chairman should request the insurance carrier to obtain it, or secure the information himself. If necessary, he should discuss the case with the defendant or other physicians.

(4) At the meeting, the case chairman presents the pertinent facts of the case which could have effect on the final decision, and answers the medical questions. The discussion relative to malpractice shall be confined to the members of the committee. The case chairman shall give his opinion as to medical malpractice prior to vote by the committee.

(5) The second phase of the discussion, before final decision, will be initiated by the attorney, if necessary. He may present legal problems or technical questions. He may ask how to defend the actions of the defendant doctor in order satisfactorily to explain them to the lay jury and the Judge.

(6) If there are no problems to delay final determination until a subsequent meeting, the committee shall recommend settlement or defense on the basis of one of the following:

(a) Settlement because of deviation from the accepted standards of good practice followed by a reasonable minority of physicians in the same specialty or practice in the same or similar community, when there is an injury resulting from such deviation.

(b) A compromise settlement for a very reasonable figure because although the case is clearly not one of malpractice, there are important principles that may make the case difficult to defend.

(c) Defense

(7) If the case is to be defended, the attorney will select the medical expert witnesses but may ask the committee to assist him in this selection. A member of the committee may, but need not, agree to serve as an expert witness.

. . . Approved the surcharge schedule presented by Mr. Britton, to be used in connection with frequent or severe claims under MSNJ's Professional Liability Insurance Program.

Council on Medical Services . . . Approved the following recommendations from the Council on Medical Services:

1. That the Board of Trustees be requested to authorize preparation of a statement explaining the Society's position in reference to physicians' fees in workmen's compensation cases involving State employees — to be promulgated to all members via *The Journal* or

the *Newsletter*. (This concerns complaints that fees are being arbitrarily reduced for services to state employees and subsequent conferences with the Deputy Attorney General and the Department of Labor.)

2. That the Governor be requested to appoint a member of MSNJ to the New Jersey Workmen's Compensation Law Study Commission.

3. Concerning Utilization Guidelines:

(a) When the Medicare carrier (Prudential), after consultation with its medical advisors, feels a question of professional conduct or ethical deportment is at issue, it be advised *to process its complaint through the judicial mechanism as the proper agency under the Bylaws of MSNJ (Chapter VII)*

(b) MSNJ does not endorse Prudential's preparation of guidelines, nor encourage Prudential to prepare them unilaterally.

. . . Directed that the above last two items be directed to the attention of the component societies and the county judicial committees.

Council on Legislation . . . Approved the following recommended positions on current legislative bills:

S-97 —To require every applicant for a motor vehicles driver's license upon first applying — and every 6 years thereafter — to submit to, and pass, a hearing and eye examination as shall be prescribed by the Director of Motor Vehicles. *ACTION DEFERRED,* pending study and recommendation by MSNJ's Special Committee on Traffic Safety — February 8, 1968.

The Council noted that several letters had been sent to the chairman of the Special Committee on Traffic Safety since the Council first deferred action on this measure pending study and recommendation from the Special Committee on Traffic Safety on February 8, 1968 without receiving acknowledgment from that Committee. As a result, the Council directed that this be brought to the attention of the President of the Society and request that he consider reconstructing the Committee and call for an emergency meeting with the members of that Committee to see why they have not rendered an opinion on this measure.

S-736—To permit licensed physicians to place or assist in placement of a new-born child for adoption and to permit attorneys to execute legal documents in connection therewith. *DISAPPROVED,* because the current procedures of operating are better for the safeguard of all concerned.

S-799—To exempt physicians and attorneys from criminal penalties in connection with adoption placements. *DISAPPROVED,* because the current procedures of operating are better for the safeguard of all concerned. (Companion bill to S-736)

The Board was of the opinion that the present adoption system is burdensome by excessive detail which retards the adoption process and should be streamlined.

S-904—To license and regulate medical care facilities; transfer powers and duties to the Department of Health from the Department of Institutions and Agencies; amends the act concerning hospital service corporations and hospital service plans and reconstitutes the board of trustees of the Hospital Service Plan to limit representation of the health profession and health care institutions to one-third. (Similar to A-932 of this year.) *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

S-921—To appropriate $295,000 to the Department of Education for the conduct and administration of special educational services for children suffering serious sensory disorders as a result of the 1962-64 Rubella Disease epidemic. *APPROVED*

A-957—To create a commission to study obscenity and depravity in public media, prescribing the commission's powers and duties, and making an appropriation therefor. *APPROVED*

A-958—To provide for the establishment of a medical assistance program. (Similar to S-850)

The Council considered Bergen County's "Proposed Amendments to A-958" and concluded that though the Society approves medicaid and the purpose of this legislation, it objects to the bill as drawn, and thus proposed its amendments to A-958.

. . . Approved the following recommendations of the Council:

1. That the Board approve the council's proposed amendments to A-958 and authorize transmission thereof to the sponsors of the measure.

2. That a meeting to discuss the proposed amendments be held with the sponsors of A-958, together with members of the Council on Legislation, keymen appointed to the Assemblymen responsible for this bill, and whomever the Chairman of the Council on Legislation may designate.

Council on Public Relations . . . Approved the following recommendations of the Council on Public Relations as continuing projects for 1968-1969:

1. Publication and distribution of Junior Health Hints to schools and libraries; Membership Newsletter; Periodical Newsletter to cooperating agencies.

2. Preparation and publication of news releases as required, including: Eye Health Screening Program; Annual Meeting; Child Safety Week; selected programs and activities.

3. Bestowal of the Golden Merit Award

4. Press Room at Annual Meeting

5. Encouragement of continuance — or establishment — of orientation programs for new members by component societies.

6. Encouragement of statewide emergency medical care coverage.

7. Encouragement of Future Physicians Clubs

Annual Meeting . . . Approved the report of the Annual Meeting Committee which included an outline of the 1969 daily schedule. (November 1968 JOURNAL, p. 619)

Committee on Emergency Medical Care . . . Approved the report of the Committee on Emergency Medical Care, including the following recommendations (as amended) pertaining to emergency room training for physicians:

(1) That MSNJ *approve investigation of the feasibility* of a training program for emergency room physicians in New Jersey and that the subject matter be of such nature as is normally recommended for emergency room physicians. (Italics indicates amendment)

(2) That the training course be given on certain days that would be convenient for physicians to attend since the training would probably take more than one day.

(3) That the training program be given in two or more areas of the State.

(4) That information be obtained from the Department of Health, Education, and Welfare, and the United States Department of Transportation concerning federal funding with regard to this program.

Joint Conference of Presidents . . . Received the report of the Chairman of the 8th Conference of Presidents of Component Societies which included discussion of the following subjects: purpose and scope of Conference; status of health examinations for working papers; minimum standards in screening children for hearing defects; establishment of neighborhood health centers; regional medical program; comprehensive health planning; abortion laws, reimbursement for services rendered patients on welfare; coordinated attack on drug addiction; membership of noncitizens; appointment of part-time legislative consultant; revision of the Medical Practice Act; Medicaid; and a supplement to the *Membership Directory.*

Report of External Auditor . . . Received a detailed report from the Society's External Auditor which noted that all recommendations are currently in operation, and commended the Business Manager for the efficient manner in which MSNJ's financial operations are being handled.

Family Health Week . . . Approved the request of Dr. Nicholas E. Marchione that MSNJ go on record as supporting one week in November as "Family Health Week."

A Commercial Side-Line— Is It Ethical?

Suppose you owned a fishing lodge, or for that matter a whole apartment house, could you ethically advertise it, noting that it was owned, operated, or supervised by John Smith, M.D., or even by Dr. John Smith? "No," says the AMA Judicial Council. "A physician must not allow his name or the prestige of his professional status to be used in the promotion of a commercial enterprise. The physician is free to engage in business ventures outside of the practice of medicine, but such business ventures should not trade on the reputation and standing of the medical profession.

If the physician advertises in this manner, the AMA Council states that the public could be misled into believing that the physician's business operation is in some way medically beneficial, that the physician provides medical supervision or care, or that it is better than the competitor's facilities because it is owned by a physician.

Justifiable or not, the layman might conclude that the reference to the physician-owner indicates superiority and perhaps health benefits. In addition, the physician's colleagues may contend that such an advertisement is a patent solicitation of patients and therefore unethical.

For these reasons, it is the opinion of the Judicial Council that such an advertisement would be improper.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of October:

	October 1968	*October 1967*
Aseptic Meningitis	41	9
Primary Encephalitis	8	1
Post-Infectious Encephalitis		
Hepatitis: Total	184	115
Infectious	145	98
Serum	39	17
Malaria	2	13
Military	2	13
Civilian		
Meningococcal Meningitis	7	11
Mumps	45	101
German Measles	8	25
Measles	40	21
Salmonella	32	64
Shigella	22	27

Eastern Encephalitis

Eleven cases of Eastern Encephalitis occurred in New Jersey residents during 1968. Dates of onset were from late July to October. There were six deaths, most of which were in the older age groups. Three patients have been left with some neurologic residual whereas two have had apparent full recovery. Since 1959 there have been 45 human cases of Eastern Encephalitis in New Jersey.

During 1968 there were 137 case of Eastern Encephalitis in horses. Cases in both categories have occurred in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, Salem, and Somerset Counties.

Measles

Though cases of measles continue to decline pockets of susceptible children are still found, especially in the cities. In October 1968, a cluster of over 30 cases was discovered in Jersey City alone. These were primarily in pre-school children and the disease spread easily among this group which lived in crowded tenements. Three were admitted to the hospital because of secondary bronchopneumonia. One of the children (age three) died.

Influenza Chemoprophylaxis 1968-69

(From *Morbidity and Mortality Weekly Report*, Vol. 17, No. 39, week ending September 28, 1968)

"During the past few years, amantadine hydrochloride, a virus chemoprophylactic, has been available. The drug is reported to prevent or modify illness caused by some strains of type A2 influenza virus if taken before exposure. Preliminary laboratory tests by the manufacturer suggest that the drug is active against the Hong Kong Variant of A2 influenza virus in eggs and might be applicable to prevention of human disease.

"In weighing the possible usefulness of amantadine hydrochloride for influenza control in 1968-69, several problems must be recognized: There has been no satisfactory study of the drug's effectiveness in the general population under conditions of natural exposure. Furthermore, in order to be protective, the drug must be administered before exposure which, in practice, necessitates giving it regularly during the entire period of possible influenza infection. Finally, the drug's acknowledged side effects are most common in older persons for whom protection is especially important.

"In view of these limitations, therefore, amantadine hydrochloride is not presently recommended as a public health measure for community control of influenza nor as a substitute for influenza vaccine immunoprophylaxis."

Tetanus

A 78 year old woman in Passaic County fell while gardening in the backyard and suffered a puncture wound of the right knee. The wound was cleansed with soap and water at home. Five days later she noticed that her false teeth did not sit right in her mouth. With the onset of dysarthria she consulted her physician and received the first tetanus toxoid immunization of her lifetime. She was hospitalized and in rapid sequence developed general spasticity and convulsions. She required a tracheostomy and mechanical respiratory assistance before her death three days after the onset of symptoms. During her brief hospital course, she was treated with antibiotics, including 30 million units of penicillin a day, and hyperimmune tetanus globulin (human) (3000 u). After the initiation of antibiotics the knee was debrided and cultured, but *Clostridium tetani* was not recovered. This is the first case of tetanus in New Jersey this year. One case was reported last year. Most tetanus cases now occur in older people. Immunization is poor among many senior citizens. The U.S.P.H.S. currently recommends booster tetanus toxoid immunization every ten years.

The Scientific Exhibits — — 203rd Annual Meeting

The following information is pertinent to the scientific exhibit displays at the 203rd Annual Meeting of this Society, May 18 to 20, 1969. Those interested in participating may use the application form on page 669. (The deadline is January 15, 1969.) Remove the page from *The Journal* and mail directly to Milton Ackerman, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Regulations

1. *Time:* The Scientific Exhibits officially will open at 10:00 a.m., Sunday, May 18, and will close at 5:00 p.m., Tuesday, May 20. Exhibits will be open on the intervening day from 9:00 a.m. to 5:00 p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 11:00 a.m., Saturday, May 17, and all exhibits must be in place by 9:00 a.m., Sunday, May 18. Exhibits must remain intact until 5:00 p.m., Tuesday, May 20, and should be removed from the exhibit hall not later than 12:00 noon, Wednesday, May 21.

3. *Cost:* The Society provides free of charge such space exhibitor may require, including booth with shelf, printed sign, and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, including electrical connections.

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold harmless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorses nor assumes any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of all exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

203rd Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 18-20, 1969

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City .....State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

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3. Is the exhibit free-standing or self-contained? .....
4. Will backwall and dividers be required? (see sketch on reverse side): .....
5. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15′, depth 6′.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear backwall .....
6. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
7. Has this exhibit been shown in whole or in part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to Milton Ackerman, M.D., Chairman Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

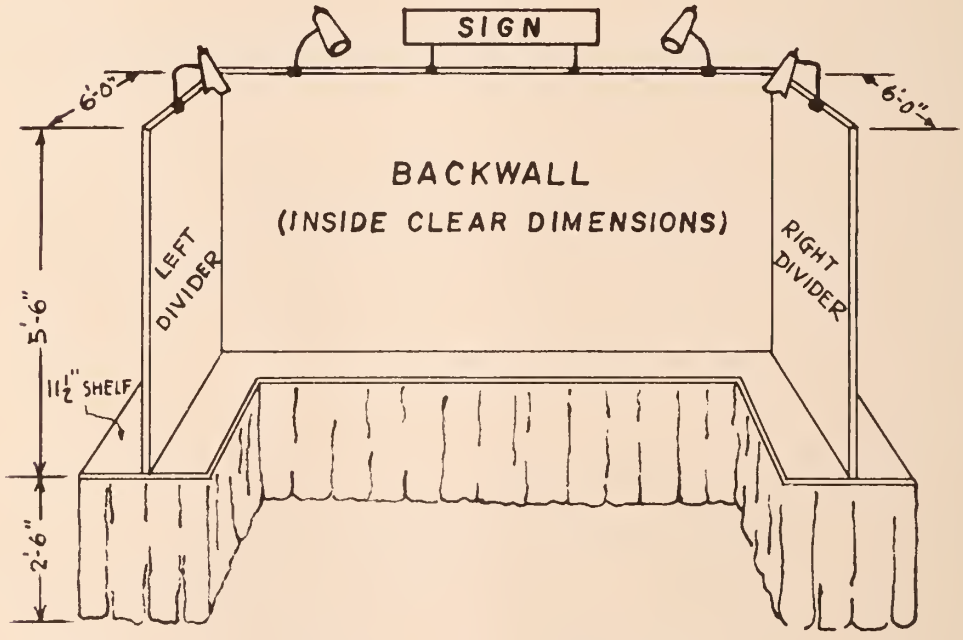
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., Apt. L-2, 121 South Highland Avenue, Ossining, New York 10562. Boston University, 1962. Board eligible. Group. Available.

Allan M. Sulzer, M.D., APO New York 09254, Tuslog Det. 37. University of Pittsburgh, 1964. Locum Tenen — November 1968-June 1969.

Irving Schiffman, M.D., 2025-A Werner Park, Fort Campbell, Kentucky 42223. Downstate Medical Center 1959. Board Certified. Subspecialty, Cardiology. Group or partnership. Available August 1968.

Raymond L. Hargrove, M.D., 44 Norman Place, Box 113, Tenafly, New Jersey. University of Pennsylvania, 1961. Board eligible. Subspecialty, Gastroenterology. Group. Available July 1969.

Stanley Feld, M.D., 24 Heather Road, Watertown, Massachusetts 02172. Downstate Medical Center, 1963. Board eligible. Subspecialty, Endocrinology. Group. Available.

Allen B. Bredt, M.D., 3509 Foxcliffe Court, Randallstown, Maryland 21133. University of Pennsylvania, 1962. Board eligible. Subspecialty, Malignant Hematology and Cancer Chemotherapy. Available July 1969.

David A. Berkowitz, M.D., 2408A Snark Street, Griffiss AFB, New York 13440. New York Medical, 1963. Board eligible. Group or partnership. Available July 1969.

OBSTETRICS AND GYNECOLOGY — Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York, 13440. Columbia, 1962. Board certified. Parnership or group. Available July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital, Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane, Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969.

Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

UROLOGY—William A. Reed, Jr., M.D., 168 Grove Park, Fort Dix 08640. Georgetown, 1958. Board certified. Partnership or group. Available December 1968.

Albert P. Tarasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

New Blood Bacteria Identification

Dr. Hugo C. Pribor, Director of the Institute of Laboratory Medicine at Perth Amboy General Hospital, has announced that scientists on his staff won a silver award for an exhibit at the 1968 annual meeting of the American Society of Clinical Pathologists. The exhibit showed a new blood culture test invented by the Associate Director of the Institute, Dr. William R. Kirkham of Edison, and their microbiologist, William R. Kozub of Metuchen.

The test has been used at the Perth Amboy Hospital during the past year and has proved more accurate, faster, and more economical than any previous method. It identifies bacteria that may have entered the blood stream. The pathogens are then identified and tested to determine which drugs are effective against them. The technic usually completes identification within 15 to 24 hours.

Any member of The Medical Society of New Jersey may obtain details by writing to Dr. Pribor at the Perth Amboy General Hospital, 530 New Brunswick Avenue, Perth Amboy 08861.

New Chairman For NJRMP

Richard J. Cross, M.D., Professor of Medicine and Associate Dean at Rutgers Medical School, has been named to succeed Joseph R. Jehl, M.D. as Chairman of the New Jersey Regional Medical Program.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
December

11 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

11 **Gloucester County Tuberculosis and Health Association**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

11 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Hypercalcemias"

11 **Mercer County Medical Society**
Trenton State Hospital — 2 p.m.
Seminar: "Emotional needs of Adolescents"
Banquet — 6:30 p.m.
Trenton Country Club

12 **The Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
Symposium: "Diabetes"

18 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Regulation of Insulin Secretion"

18 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Cardiogenic Shock"

19 **The Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Symposium: "The Premature Infant"

26 **Gloucester County Medical Society**

26 **Morris County Medical Society**

1969
January

7 **Hudson County Medical Society**
"Cancer In Situ"

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 and 15 **Muhlenberg Hospital**
Plainfield
"Kidneys and Electrolytes"

8 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Rationale for Modern Treatment of Diabetes"

8 **The Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
"Management of the Menopause"

14 **Bergen County Medical Society**

15 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"New Aspects of Cor Pulmonale"

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Medicare and Medicaid in Family Practice"

21 **The Academy of Medicine of New Jersey**
Section on Dentistry
Fairleigh Dickinson School of Dentistry
Teaneck
"Anthropology in Growth and Development in Relation to Dentistry"

22 **The Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: "Coronary Care"

22 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Diabetes Mellitus"

22 and 23 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

27 **Cape May County Medical Society**

28 **Hunterdon County Medical Society**

29 **The Academy of Medicine of New Jersey**
Section on Pediatrics
Morristown Memorial Hospital
"Neuroblastomas"

February

4 **Hudson County Medical Society**
"Recent Advances In Cancer Therapy"

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

14-15 **American College of Surgeons**
New Jersey Chapter
Trip to Cleveland Clinic
Cleveland, Ohio

18 **Warren County Medical Society**

19 **The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Symposium: "What's New in Cancer"

19 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment of Ski Injuries"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Cancer Chemotherapy"

26 **New Jersey Gastroenterological Society Newark**

26 to Mar. 1 **New Jersey Academy of General Practice**
Sheraton-Deauville Hotel
Atlantic City
Convention

March

4 **Hudson County Medical Society**
"Modern Concepts About Immunization"

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Marriott Motor Inn
Saddle River
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

19 **The Academy of Medicine of New Jersey**
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Rheumatic Fever: Diagnosis and Treatment"

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

31 **Cape May County Medical Society**

April

1 **Hudson County Medical Society**
"Changes In Medical Care and Practice"

2 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Symposium: "Gynecological Neoplasms"

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

2 and 9 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Pediatric Symposium

16 **The Academy of Medicine of New Jersey**
Section on Dentistry
VA Hospital, East Orange
Symposium: "The Dentist's Role In Facial Pain And Its Management"

16 and 23 — Muhlenberg Hospital
Plainfield
"Infectious Diseases"

17 — Gloucester County Medical Society

17 — Morris County Medical Society

23 — Bergen Pines County Hospital
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

26 — Kessler Institute of Rehabilitation
Mayfair Farms
West Orange
20th Anniversary Dinner

May

6 — Hudson County Medical Society
Election of Officers

7 — Bergen Pines County Hospital
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

13 — Bergen County Medical Society

14 — Gloucester County Tuberculosis and Health Association

14 — Ocean County Medical Society

15 — Gloucester County Medical Society

15 — Morris County Medical Society

17-21 — MSNJ Annual Meeting
Haddon Hall
Atlantic City

18 — The Academy of Medicine of New Jersey
Symposium: "The Diagnosis of Life and Death

20 — Warren County Medical Society

21 — Bergen Pines County Hospital
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

22 — Essex and Morris County Medical Societies with Sandoz Pharmaceuticals
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

26 — Cape May County Medical Society

27 — Hunterdon County Medical Society

28 — Middlesex County Medical Society

June

10 — Bergen County Medical Society

10 — Cumberland County Medical Society

11 — Gloucester County Tuberculosis and Health Association

11 — Middlesex County Medical Society

11 — Ocean County Medical Society

17 — Warren County Medical Society

19 — Gloucester County Medical Society

19 — Morris County Medical Society

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OBITUARIES

Samuel J. Penchansky, M.D.

On October 26, 1968, a heart attack took the life of Dr. Samuel J. Penchansky. A member of our Hudson County Medical Society, Dr. Penchansky was a well known hematologist and was chief of pathology at the Fairmount Hospital in Jersey City. He had served in the U.S. Air Forces during World War II, reaching the rank of lieutenant colonel. Some years ago, he was the laureate of the annual award of the National Council of Christians and Jews. Born in 1907, Dr. Penchansky received his M.D. in 1929 at the University of Maryland.

Dr. Edward F. Sciorsci

Announcement has been made of the death on November 5, 1968, of Edward F. Sciorsci, M.D. Dr. Sciorsci was born in 1903 and received his M.D. at Long Island College of Medicine in 1929. He was director of medical education at St. Francis Hospital in Jersey City, a consulting surgeon at St. Mary's Hospital in Hoboken, and an attending surgeon at the Jersey City Medical Center. Dr. Sciorsci was a general surgeon with special interest in gastro-intestinal surgery. He was a Fellow of the American College of Surgeons and of the American College of Gastroenterology.

Dr. Reuben L. Sharp

One of New Jersey's top medical leaders left us on October 17, 1968 with the death that day of Reuben L. Sharp, M.D., a past-president of the Camden County Medical Society. Dr. Sharp was 71 years old at the time of his death. He received his M.D. degree at the University of Pennsylvania in 1926 and interned at the Cooper Hospital in Camden. Dr. Sharp was a board-certified internist, with special interest in gastro-enterology. He had one of the longest periods of service on the Board of Trustees of The Medical Society of New Jersey. He served on the Board for almost 30 years, and was twice Chairman of the Board, and three times its secretary. Dr. Sharp was a much-decorated medical officer with the fourth Marine Division during world war II.

Dr. William S. Spranz

At the age of 60, Dr. William S. Spranz, a well-known Bergen County general practitioner, died on October 10, 1968. Dr. Spranz was a 1933 graduate of the medical school of St. Louis University. He was affiliated with both the Pascack Valley Hospital and the Hackensack Hospital. Dr. Spranz was active in committee work for the Bergen County Medical Society.

Dr. Allen A. Welkind

In his all too short profession life, Murph Welkind had several careers. Born in 1910, he earned his M.D. at Long Island in 1934. After interning at Newark Beth Israel, he did graduate work in internal medicine and was Board certified in 1945. Dr. Welkind served in Africa in World War II as a flight surgeon. He did research in respiratory and cardiovascular physiology. At that period of his life "dynamics" meant cardiac dynamics, but after he was mustered out of the Army "dynamics" took on another meaning—psychodynamics. He became increasingly interested in psychiatry and served a residency at the Essex County Overbrook Hospital. He won a Fellowship in the American Psychiatric Association to stand beside his Fellowship in the American College of Physicians.

Dr. Welkind then limited his practice more and more to psychiatry and psychosomatics. In addition to this he had an interest in spinal cord neurology and was the medical director of our state's Multiple Sclerosis Association. He was a member of the faculty of the New Jersey College of Medicine. This promising and many-sided professional life was abruptly terminated on October 9, 1968, when he died following a cerebral hemorrhage

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Index 1968

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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin. Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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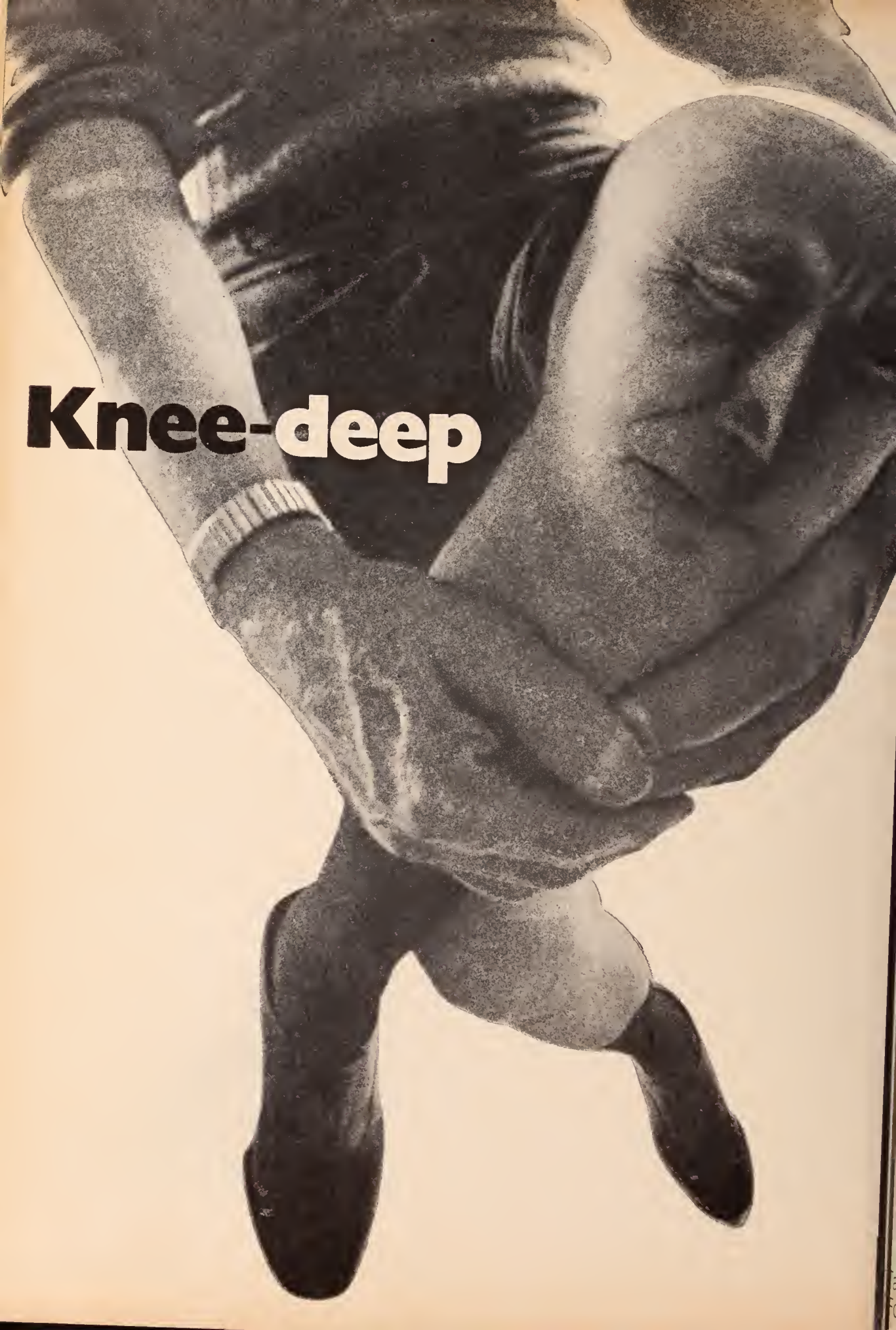
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

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The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

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Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006



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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.

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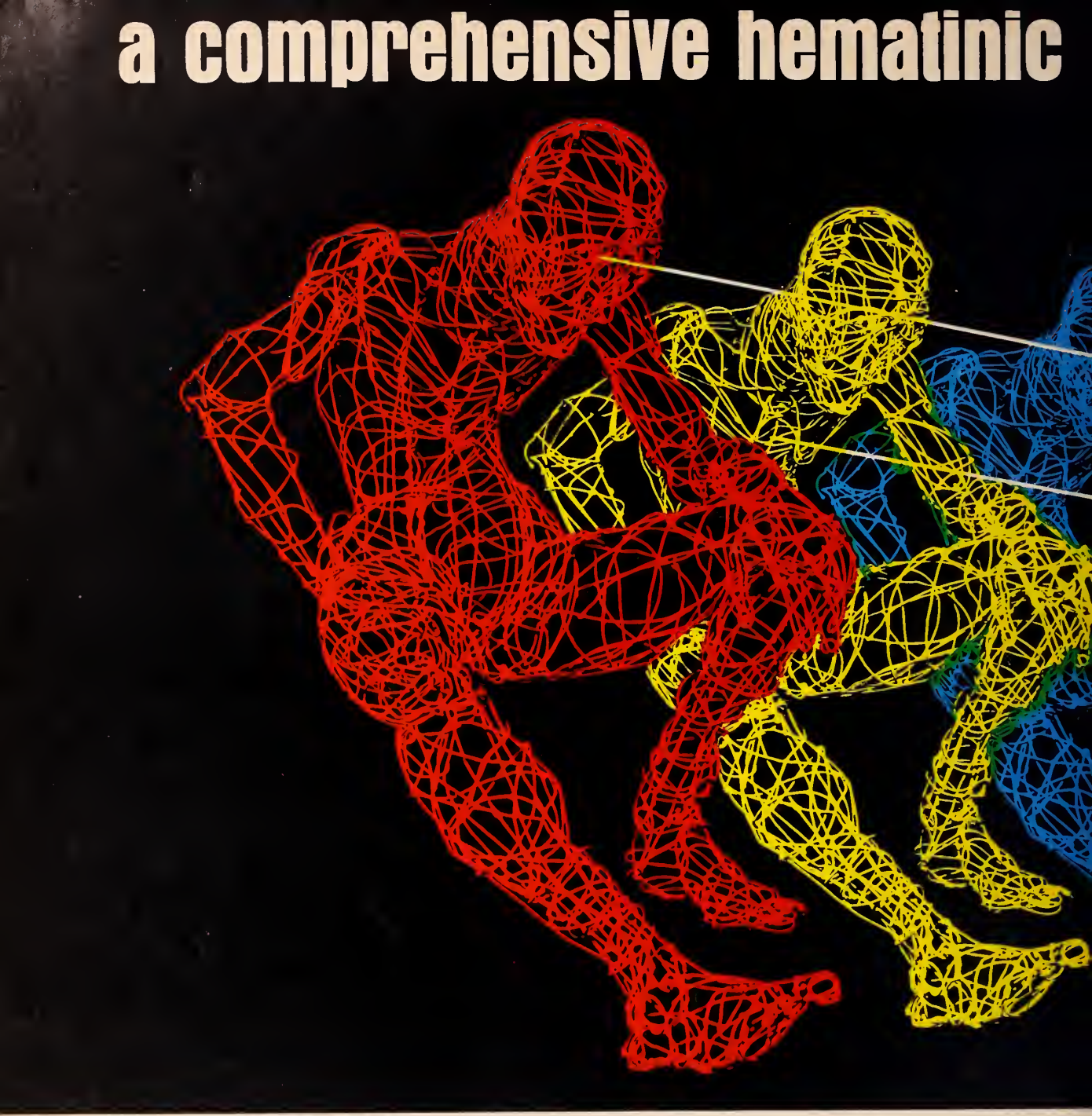
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Description: Each Pulvule® contains—

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Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

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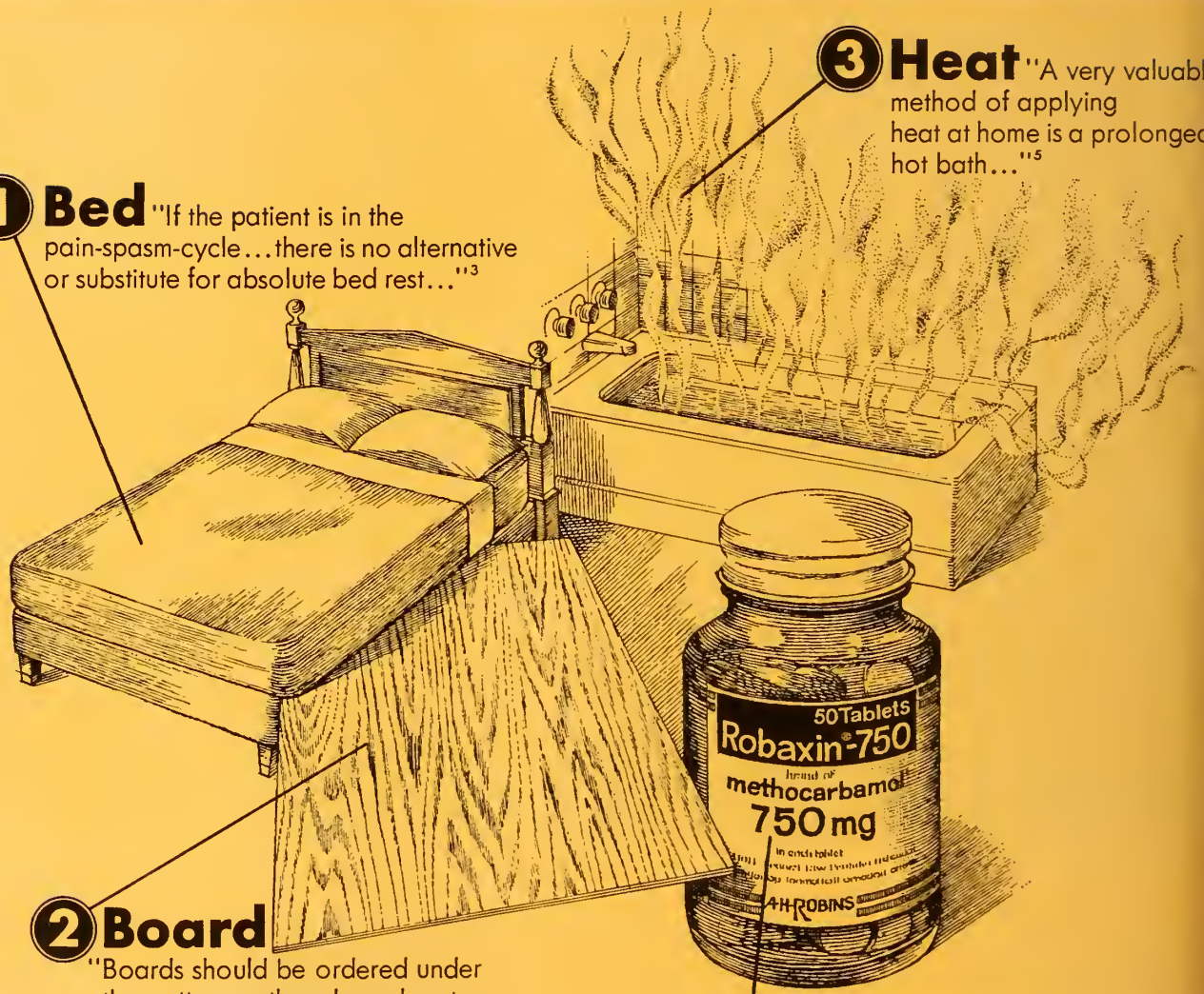
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References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottscholk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dokoto J. Med. 18:26, 1965. (5). Soto-Holl, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. ond Weiss, S.: J. Am. Osteopoth. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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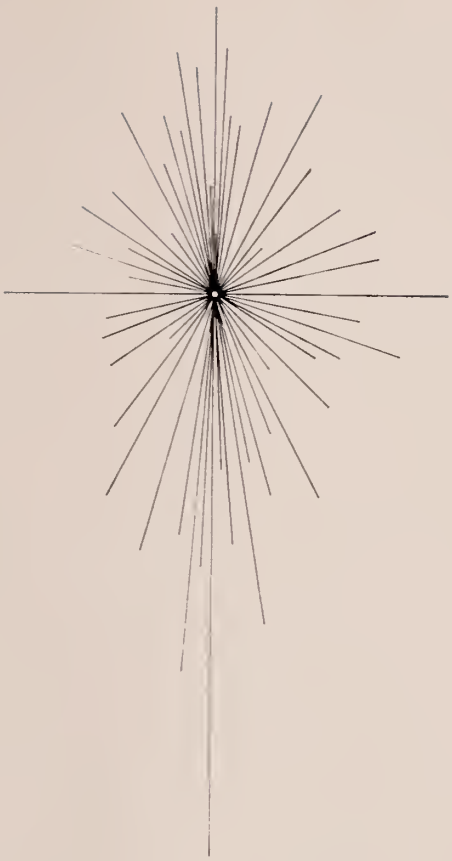
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However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®
(diazepam)

ROCHE

Roche®
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

R. R.

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER